96TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
No. 96–568

CHILD HEALTH ASSURANCE ACT OF 1979

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

together with

SEPARATE, ADDITIONAL, AND DISSENTING VIEWS AND INCLUDING THE CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

[TO ACCOMPANY H.R. 4962]

OCTOBER 26, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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CHILD HEALTH ASSURANCE ACT OF 1979

OCTOBER 26, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

MR. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

[To accompany H.R. 4962]

[Including cost estimate of the Congressional Budget Office]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 4962) to amend title XIX of the Social Security Act to strengthen and improve medicaid services to low-income children and pregnant women, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 3, insert "and" at the end of line 12.

Page 4, line 14, insert "if the pregnancy terminated as a result of a birth, miscarriage, or an abortion performed to save the life of the mother or to terminate a pregnancy resulting from rape or incest" after "pregnancy".

Page 5, line 23, insert "if the pregnancy terminated as a result of a birth, miscarriage, or an abortion performed to save the life of the mother or to terminate a pregnancy resulting from rape or incest" after "pregnancy".

Page 10, line 19, strike out "(a)" and insert in lieu thereof "(A)".

Page 10, line 21, insert after "individual" the following: "described in paragraph (10)(A) and".

Page 10, line 23, strike out "section 1092(a)" and insert in lieu thereof "paragraph".

Page 12, line 17, strike out "physiological" and insert in lieu thereof "psychological".

Page 12, line 21, strike out "of following" and insert in lieu thereof "the following".

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Page 22, line 5, insert after "ineligible" the following:

> or, in the case of any such individual with a condition which cannot be corrected through treatment but which can be controlled or stabilized through treatment, until the end of the 12-calendar-month period beginning with the month in which the individual became ineligible.

Page 23, beginning in line 1, strike out "until the end of the 60-day period beginning on the date of the termination of her pregnancy" and insert in lieu thereof

> until the end of her pregnancy or if the pregnancy terminated as a result of a birth, miscarriage, or an abortion performed to save the life of the mother or to terminate a pregnancy resulting from rape or incest until the end of the 60-day period beginning on the date of the termination of her pregnancy.

Page 33, line 7, strike out "1902(b)(3)" and insert in lieu thereof "1902(b)(3) (as amended by section 3 (b)(2) of this Act)".

Page 33, line 11, strike out "1902(b)(4)" and insert in lieu thereof "1902(b)(3) (as amended by section 3(b)(2) of this Act)".

Page 33, insert a close quotation mark at the end of line 20.

Page 34, insert after line 22 the following:

> This section does not authorize the enactment of new budget authority.

Page 37, beginning in line 3 strike out "after the date of the enactment of this Act" and insert in lieu thereof "after the effective date prescribed by section 16(a)(1)".

Page 37, beginning in line 15 strike out "The Secretary shall obligate for purposes of subsection (a)" and insert in lieu thereof "For the fiscal year ending September 30, 1981, and for each fiscal year thereafter there are authorized to be appropriated for purposes of carrying out subsection (a) an amount equal to" and at the end of line 16 on that page insert "in the preceding fiscal year".

Page 40, beginning in line 18, strike out "and 13 (relating to continuing medical eligibility for certain individuals by disregarding certain involuntary increases in income)".

Legislative Background

Legslation to amend title XIX (Medicaid) of the Social Security Act to expand and improve Medicaid coverage for poor children and low-income pregnant women, and to modify and improve current Medicaid screening and treatment requirements for children through establishment of a child health assurance program (CHAP), was introduced as H.R. 2159, by Mr. Carter, ranking Republican member of the Subcommittee on Health and the Environment, as H.R. 2461; by Mr. Maguire and Mr. Waxman, Chairman of the Subcommittee on Health and the Environment; and as H.R. 4053, by Mr. Waxman for the Administration. Hearings were conducted on these bills, and all similar or identical legislation, by the Subcommittee on Health and the Environment on June 7 and June 11, 1979. The bills were subsequently considered in open session by the Subcommittee, combined into a single

legislative proposal, ordered reported by voice vote, as a clean bill, which was introduced as H.R. 4962 on July 25, 1979. A motion to consider H.R. 4962 was agreed to by the Committee on Interstate and Foreign Commerce on September 27, 1979, and the bill was ordered reported with amendments by a vote of 17 to 5 on October 16, 1979.

Companion legislation has been introduced in the Senate, as S. 1204, and has been reported by the Senate Finance Committee. There has been no action by the Senate to date.

Summary of the Legislation:

The legislation makes additional children and pregnant women eligible for Medicaid coverage; establishes a nationwide minimum income standard for coverage of pregnant women and children, although any State has the option of covering persons with higher incomes; broadens health care benefits provided to Medicaid children; increases the proportionate share of the costs of health assessments and outpatient treatment for Medicaid children which is paid for by the Federal government; provides incentives for more successful operation of health assessment and outreach and follow-up programs by the States; assures that all types of eligible health care providers and agencies may serve as CHAP providers for Medicaid children; provides incentives to facilitate enrollment of Medicaid children with health care providers who will give primary and preventive care on a continuing basis, including HMOs and provides for penalties (in the form of reduced matching of administrative costs) for States which do not meet minimum performance standards in their CHAP programs, and bonuses for those that perform exceptionally well.

Specifically, the legislation would do the following:

I. ELIGIBILITY

A. The legislation requires States to provide Medicaid for all individuals under 18 years of age who are financially eligible under the State Medicaid standard, or who have income of less than 2/3 of the poverty level established for a family of that size. Children would be covered whether they are members of an intact family or not. (Current law requires States only to cover children in broken families). Additionally, it makes Federal matching funds available for medical services to financially eligible individuals up to age 21, although coverage for children over 17 would be at the option of the State.

The legislation provides for a 4-month extension of Medicaid coverage for any child who would otherwise become ineligible because of an increase in his family's income or resources. For a child with a condition which is not correctable, but which can be controlled or stabilized through treatment, the legislation provides that the extension of eligibility would be for 12 months, rather than limited to four. It also provides for an additional extension of Medicaid eligibility for a child with a correctable medical condition until that condition is corrected.

B. The legislation provides Medicaid eligibility for all pregnant women who are financially eligible under the State Medicaid standard, or who have income of less than 80 percent of the poverty level for an

individual, or, if the woman is already part of a family, for a family of that size. The period of eligibility would be for the course of the pregnancy, and the first two months following birth. The child born to the woman would also be eligible during the two-month period following the pregnancy. These women and their children would be eligible for all Medicaid services included in the State plan, including appropriate prenatal and postnatal care. (A woman whose pregnancy was terminated by an abortion would not be eligible for the additional 60 days of coverage after pregnancy, unless that abortion was performed to save the life of the mother, or to terminate a pregnancy resulting from rape or incest.)

C. The legislation gives States an option to provide Medicaid coverage to adopted children who have been in foster care, and who were hard-to-place for adoption because of a handicapping or medical condition requiring medical care. regardless of the income level of the adopting family. Eligibility would continue until the child reaches 18 (or 21, if States cover children up to that age), or until the medical services are no longer required. A State can provide Medicaid coverage for all services covered in its Medicaid program, or only those required to treat the condition.

D. The legislation clarifies the Secretary's authority to determine State of residence for purposes of Medicaid coverage where intent-to-reside is at issue (increasing the accessibility of Medicaid coverage to migrants and other individuals, particularly in institutions, who have traditionally had difficulty establishing eligibility because of differing State policies on residency). Residency requirements relating to U.S. citizenship or lawful admission for permanent residency, currently contained in regulation, are included in the legislation.

E. The legislation allows children who are inmates of public institutions to remain eligible for Medicaid if they were eligible before entry into the facility. (Current law provides that Medicaid eligibility ceases when a person becomes an inmate of a public institution which is not a medical institution).

II. SERVICES

A. The legislation requires that all Medicaid programs provide a full range of primary and preventive services to Medicaid children. In addition to services currently required under Medicaid, all States must provide coverage of child health assessments, immunizations, routine dental care, diagnosis and treatment of vision and hearing problems (including hearing aids and eyeglasses), prescribed drugs and insulin, prosthetic devices, home health services, physical therapy, rehabilitative services, ambulatory mental health services, and emergency crisis intervention inpatient mental health services for children. States could not set limits on the amount, duration or scope of these services for children, or require copayments.

B. The legislation requires prenatal and postnatal services to be provided in all Medicaid programs.

III. PROVIDERS

A. The legislation requires States to allow all qualified health care providers who will agree to do asessments and necessary referral and

follow-up to participate in the program, including physicians, public health departments, community health centers, headstart agencies, rural health clinics, HMOs, and maternal and child health centers. Additionally, provision is made to allow States to sign agreements with school systems which have made arrangements for assessments.

B. The legislation includes incentives to encourage use of continuing care providers for children; that is, providers who give basic primary and preventive care and who agree to provide care to specific children on a continuing basis.

C. The legislation requires States to reimburse providers at a level which can reasonably be expected to elicit adequate provider participation to carry out the program. The Secretary is given general authority to establish standards for payments to continuing care providers, and to require payment to HMOs at a rate of 95 percent of the average medical assistance payment for a child in a State.

D. The legislation requires the Secretary to undertake a study of provider participation in CHAP, and ways to improve it, and to carry out demonstrations of capitation arrangements with physicians for provision of CHAP services.

IV. FEDERAL SHARE OF PROGRAM COSTS

A. The legislation provides for an increase in the Federal matching rate for assessments, and for all non-inpatient services provided to children who have a current assessment. The new Federal matching rate is generally calculated by adding 25 percentage points to the current matching rate for each State, up to a maximum Federal matching rate of 90 percent, except for chilren who are enrolled with a continuing care provider, when the increase is 30 percentage points, up to a maximum rate of 95 percent.

B. The legislation requires a maintenance of effort by States regarding services for and coverage of children, as a condition for receiving the higher Federal matching rate; that is, they may not lower their eligibility standards or discontinue services for children during the first four years the higher matching rate is available.

C. The legislation increases the Federal matching rate for costs of outreach and follow-up to 75 percent (administrative costs are generally matched at 50 percent under current law). States are required to allocate a reasonable proportion of program funds for outreach activities.

D. The legislation establishes standards for minimal performance and reasonable performance for a child health assurance program. States which do better than the reasonable level of performance receive gradual increases in the Federal share of the administrative costs; the maximum bonus is a 25 percent increase in the Federal share. States which fail to meet the minimum standard are subject to a penalty in the form of a 20 percent reduction in the Federal share of the administrative costs of the Medicaid program. The Secretary would have the authority to delay imposition of the penalty for 6 months where he found a State was making a good faith effort to comply and to waive it if compliance is achieved in that time period. The penalty provision of the current law is repealed.

Cost of Legislation

H.R. 4962 changes the provisions of title XIX of the Social Security Act (Medicaid), which is an entitlement program. Estimated impact of the legislation on Federal and State Medicaid expenditures follows:

INCREMENTAL COSTS OF CHAP, FISCAL YEARS 1980–84

[By fiscal year, in millions of dollars]

	1980	1981	1982	1983	1984
Total	126	639	1,071	1,541	1,921
Federal	131	646	1,123	1,612	1,995
State	−5	−7	−52	−71	−74

[1] Costs are for ¼ of the fiscal year only.

Background and Need for the Legislation

CURRENT LAW

A. The Medicaid Program

Title XIX of the Social Security Act (Medicaid) provides for a program of medical assistance for certain low-income individuals and families. In its general structure, Medicaid is a financing program: it makes payments to providers of medical care for covered medical services for eligible persons.

With some minor exceptions (relating to the aged and disabled), a State Medicaid program is required to cover individuals and families who receive payments through the welfare program, Aid to Families with Dependent Children (AFDC), and the Supplemental Security Income Program (SSI). A State may also provide Medicaid to these same categories of people (that is, aged, blind or disabled individuals, or members of families where one parent is absent, incapacitated, or unemployed) who have slightly too much money to be on welfare, but not enough to pay for their medical care. When a State provides this kind of coverage, it is said to have a program for the medically needy.

A State also has options available to it regarding who is covered in its AFDC program. A State is required only to cover families where one parent is absent or incapacitated. It may provide AFDC to families where one parent is unemployed. If these families are covered in the State AFDC program, they then become eligible for Medicaid.

In addition to the groups of people who are eligible because they fit into one of the categories of persons who are covered by the welfare programs a State has the option to include any poor children under 21 in its Medicaid program. 18 States have done this, as well as Puerto Rico and the Virgin Islands.

The result of the various options available to the States is that they are required to provide Medicaid only to children in broken families. They may, of course, provide coverage to others, but many States have not chosen to do so. The following table summarizes the current status of State coverage of children.

OPTIONAL MEDICAID COVERAGE GROUPS, JANUARY, 1979

State	Unemployed fathers and their families	Children of unemployed fathers	All financially eligible individuals under age 21
Alabama			
Alaska			
Arizona [1]			
Arkansas			X
California	X	X	X
Colorado	X	X	
Connecticut	X	X	X
Delaware	X	X	
District of Columbia	X	X	X
Florida			
Georgia			
Guam	X	X	
Hawaii	X	X	X
Idaho			
Illinois	X	X	
Indiana			
Iowa	X	X	
Kansas	X	X	
Kentucky	X	X	
Louisiana			
Maine			X
Maryland	X	X	X
Massachusetts	X	X	X
Michigan		X	X
Minnesota	X	X	X
Mississippi			
Missouri	X	X	
Montana	X	X	
Nebraska	X	X	
Nevada			
New Hampshire			
New Jersey	X	X	X
New Mexico			
New York	X	X	X
North Carolina			
North Dakota			
Ohio	X	X	
Oklahoma			X
Oregon	X	X	
Pennsylvania	X	X	X
Puerto Rico	X	X	X
Rhode Island	X	X	
South Carolina			
South Dakota			
Tennessee			
Texas			
Utah	X	X	X
Vermont	X	X	X
Virgin Islands	X	X	X
Virginia			
Washington	X	X	X
West Virginia	X	X	
Wisconsin	X	X	X
Wyoming			
Total	30	31	20

[1] No Medicaid program.

Source: Health Care Financing Administration, HEW.

Federal matching funds help States pay for the costs of Medicaid. The Federal government pays between a minimum of 50 percent and a maximum of 83 percent (with the higher matching rate available to States with low per capita incomes) of the cost of benefits paid for under the Medicaid program. With the exception of payments for family planning services (where the Federal matching rate is 90 percent), the Federal matching rate is the same for any service provided under Medicaid, whether it is a mandatory or optional service, and whether it is provided to a person who must receive Medicaid coverage or to a person who is covered at the State's option. Administrative costs are generally matched at 50 percent.

Because of State establishes the income level for AFDC eligibility and for any supplementary payments to the Federal SSI benefits, as

well as the income level for the medically needy if it covers that group, each State in effect establishes the income eligibility level for its Medicaid program. As a result, there is wide variation from State to State: one State covers 4-person families only if their income does not exceed $2400 a year, another allows an annual income of nearly $7000. The following tables present the most recent available information on the income levels used by the States. In the first table, the difference between a "need" standard and a "payment" standard is that the need standard is used in determining a family's eligibility (i.e., if their incomes fall below the need standard, and they meet all other requirements, they would be eligible for AFDC); the payment standard is used in determining how much a family with no income would be paid by the AFDC program. In most States the two standards are the same, but in some the payment standard is less than 100 percent of need, meaning that the cash grant may be less than required to raise the family's income up to the need standard.

ANNUAL NEED AND PAYMENT STANDARD FOR AN AFDC FAMILY OF 2, AND AN AFDC FAMILY OF 4, AS OF JULY 1, 1978

State	2-person family			4-person family		
	Need	Payment	Highest amount paid	Need	Payment	Highest amount paid
Alabama	$1,728	$1,068	$1,068	$2,880	$1,776	$1,776
Alaska	4,200	4,200	4,200	5,400	5,400	5,400
Arizona	2,160	1,620	1,620	3,384	2,544	2,544
Arkansas	2,316	1,596	1,596	3,276	2,256	2,256
California	3,564	3,444	3,444	5,328	5,076	5,076
Colorado	2,492	2,492	2,492	3,779	3,779	3,779
Connecticut	4,092	4,092	4,092	5,904	5,904	5,904
Delaware	2,172	2,172	2,172	3,444	3,444	3,444
District of Columbia	2,712	2,436	2,436	4,188	3,768	3,768
Florida	1,800	1,536	1,536	2,760	2,352	2,352
Georgia	1,932	1,260	1,260	2,724	1,776	1,776
Hawaii	4,680	4,680	4,680	6,552	6,552	6,552
Idaho	3,576	3,120	3,120	5,052	4,404	4,404
Illinois	2,724	2,724	2,724	3,996	3,996	3,996
Indiana	2,964	2,664	2,100	4,356	3,924	3,300
Iowa	3,300	3,300	3,300	4,740	4,740	4,740
Kansas	3,288	3,288	3,288	4,368	4,368	4,368
Kentucky	1,620	1,620	1,620	2,820	2,820	2,820
Louisiana	2,880	1,212	1,212	4,920	2,064	2,064
Maine	2,460	2,220	2,220	4,188	3,768	3,768
Maryland	2,436	2,064	2,064	3,768	3,204	3,204
Massachusetts	3,348	3,348	3,348	4,752	4,752	4,752
Michigan	3,708	3,708	3,708	5,388	5,388	5,388
Minnesota	3,600	3,600	3,600	5,088	5,088	5,088
Mississippi	2,256	2,256	720	3,024	3,024	1,212
Missouri	3,000	2,100	2,100	4,380	3,072	3,072
Montana	2,004	2,004	2,004	3,972	3,972	3,972
Nebraska	3,000	3,000	3,000	4,440	4,440	4,440
Nevada	2,748	2,220	2,220	4,092	3,312	3,312
New Hampshire	3,156	3,156	3,156	4,152	4,152	4,152
New Jersey	2,964	2,964	2,964	4,488	4,488	4,488
New Mexico	1,920	1,920	1,848	2,868	2,868	2,748
New York	3,996	3,996	3,996	5,712	5,712	5,712
North Carolina	1,908	1,908	1,908	2,400	2,400	2,400
North Dakota	2,820	2,820	2,820	4,440	4,440	4,440
Ohio	3,408	2,304	2,304	5,172	3,492	3,492
Oklahoma	2,376	2,376	2,376	3,708	3,708	3,708
Oregon	3,564	3,252	3,252	5,292	4,836	4,836
Pennsylvania	3,120	3,120	3,120	4,476	4,476	4,476
Rhode Island	3,228	3,228	3,228	4,544	4,544	4,544
South Carolina	1,728	1,728	936	2,748	2,748	1,488
South Dakota	3,108	3,108	3,108	4,080	4,080	4,080
Tennessee	1,704	1,164	1,164	2,604	1,776	1,776
Texas	1,380	1,032	1,032	2,244	1,680	1,680
Utah	3,792	2,916	2,916	5,832	4,488	4,488
Vermont	5,016	4,140	4,140	6,924	5,724	5,724
Virginia	3,024	2,880	2,880	4,464	4,020	4,020
Washington	3,696	3,696	3,696	5,268	5,268	5,268
West Virginia	2,628	1,968	1,968	3,984	2,988	2,988
Wisconsin	4,452	3,912	3,912	6,240	5,496	5,496
Wyoming	2,940	2,940	2,940	3,660	3,660	3,660

Source: Health Care Financing Administration projections from monthly standards listed in HEW Publication No. SSA–79–11924, AFDC Standards for Basic Needs, July 1978.

INCOME LEVELS FOR MEDICALLY NEEDY IN TITLE XIX PLANS IN OPERATION AS OF JULY 1978[1]

[Annual income]

State	Income protected for maintenance, by number of family members				
	1	2	3	4	Plus dollars for additional persons
Arkansas	$1,700	$2,200	$2,600	$3,100	5—$3,500; 6—$3,900; 7—$4,200; 8—$4,600; 9—$4,900; 10—$5,200; $300 for each additional person.
California	2,652	3,804	4,704	5,604	5—$6,396; 6—$7,200; 7—$7,896; 8—$8,604; 9—$9,300; 10—$9,996.
Connecticut:					
Region A	3,300	4,500	5,100	6,000	5—$6,700; 6—$7,500; 7—$8,300; 8—$9,200; 9—$9,800; 10—$10,700.
Region B	3,100	4,200	4,400	5,100	5—$5,900; 6—$6,600; 7—$7,500; 8—$8,300; 9—$8,900; 10—$9,800.
Region C	2,900	4,100	4,300	5,000	5—$5,700; 6—$6,500; 7—$7,200; 8—$8,000; 9—$8,700; 10—$9,700.
District of Columbia	2,300	3,500	3,700	3,900	5—$4,352; 6—$5,119; 7—$5,875; 8—$6,491; 9—$7,139; 10—$7,754.
Guam	1,500	2,500	2,800	3,000	5—$3,200; 6—$3,400; 7—$3,600; 8—$3,800; 9—$4,000; 10—$4,200; $200 for each additional person.
Hawaii	3,600	4,800	5,600	6,600	5—$7,500; 6—$8,400; 7—$9,600; 8—$10,200; 9—$10,800; 10—$11,400; $600 for each additional person.
Illinois	2,100	2,600	3,100	3,800	5—$4,500; 6—$5,100; 7—$5,800; 8—$6,100; 9—$6,700; 10—$10,300; $576 for each additional person.
Kansas	3,400	4,000	4,400	4,900	5—$5,400; 6—$5,900; 7—$6,200; 8—$6,600; 9—$7,000; 10—$7,300; $360 for each additional person.
Kentucky	1,800	2,200	3,000	3,800	5—$4,400; 6—$5,000; 7—$5,600; 8—$6,200; 9—$6,800; 10—$7,400; $600 for each additional person.
Louisiana:					
Urban	1,500	1,704	2,304	2,796	5—$3,300; 6—$3,696; 7—$4,200; 8—$4,596; 9—$5,004; 10—$5,496.
Rural	1,296	1,500	2,100	2,604	5—$3,096; 6—$3,504; 7—$3,996; 8—$4,404; 9—$4,800; 10—$5,196.
Maine	2,520	3,200	4,300	5,400	5—$6,400; 6—$7,500; 7—$8,600; 8—$9,700; 9—$10,800; 10—$11,800; $1,068 for each additional person.
Maryland	2,300	2,800	3,300	3,800	5—$4,300; 6—$4,800; 7—$5,300; 8—$5,800; 9—$6,300; 10—$6,800; $504 for each additional person.
Massachusetts	3,600	4,500	4,680	5,280	5—$5,880; 6—$6,480; 7—$7,080; 8—$7,680; 9—$8,280; 10—$9,000; $720 for each additional person.
Michigan[2] (Wayne Co.)	2,598	3,468	4,200	5,040	5—$5,856; 6—$6,672; 7—$7,428; 8—$8,164; 9—$8,490; 10—$9,696; $756 for each additional person.
Minnesota	2,000	3,300	3,900	4,500	5—$5,100; 6—$6,000; 7—$6,400; 8—$7,000; 9—$7,600; 10—$8,200; $624 for each additional person.
Montana	2,004	3,444	4,008	4,572	5—$5,136; 6—$5,700; 7—$6,264; 8—$6,828; 9—$7,392; 10—$7,956.
Nebraska	3,100	4,000	4,800	5,600	5—$6,400; 6—$7,200; 7—$8,000; 8—$8,800; 9—$9,600; 10—$10,400; $400 for each additional person.
New Hampshire	3,000	3,500	4,100	4,600	5—$5,100; 6—$5,700; 7—$6,200; 8—$7,000; 9—$7,400; 10—$5,200; $564 for each additional person.
New York	3,100	4,400	4,500	5,000	5—$5,800; 6—$6,500; 7—$7,400; 8—$8,096; 9—$8,792; 10—$9,488; $696 for each additional person.
North Carolina	1,700	2,200	2,500	2,800	5—$3,000; 6—$3,200; 7—$3,400; 8—$3,600; 9—$3,800; 10—$4,000; $100 for each additional person.
North Dakota	2,400	3,400	4,300	5,300	5—$6,000; 6—$6,600; 7—$7,100; 8—$7,400; 9—$7,700; 10—$8,000; $228 for each additional person.
Oklahoma	2,600	3,200	4,100	5,000	5—$5,800; 6—$6,600; 7—$7,400; 8—$8,000; 9—$8,700; $600 for each additional person.
Pennsylvania	2,700	4,000	4,250	4,500	5—$5,100; 6—$5,550; 7—$6,200; 8—$6,850; 9—$7,500; 10—$8,150; $325 for each additional person.
Puerto Rico	2,500	3,200	3,800	4,400	5—$5,000; 6—$5,600; 7—$6,200; 8—$6,800; 9—$7,400; 10—$8,200; $600 for each additional person.
Rhode Island	3,600	4,300	5,300	6,100	5—$6,800; 6—$7,700; 7—$8,500; 8—$9,300; 9—$10,000; $400 for each additional person.
Tennessee	1,404	1,600	2,000	2,400	5—$2,800; 6—$3,300; 7—$3,700; 8—$4,100; 9—$4,600; 10—$5,000; $264 for each additional person.
Utah	2,700	3,800	4,800	5,800	5—$7,200; 6—$8,400; 7—$8,900; 8—$9,400; 9—$9,984; 10—$10,500.
Vermont	3,288	4,224	5,028	5,724	5—$6,504; 6—$7,008; 7—$7,788; 8—$8,520; 9—$9,216; 10—$9,912; $696 for each additional person.
Virgin Islands	2,200	2,800	3,200	3,600	5—$4,100; 6—$4,500; 7—$5,000; 8—$5,400; 9—$5,800; 10—$6,300; $440 for each additional person.

See footnotes at end of table.

INCOME LEVELS FOR MEDICALLY NEEDY IN TITLE XIX PLANS IN OPERATION AS OF JULY 1978 [1]—Continued

[Annual income]

State	Income protected for maintenance, by number of family members				
	1	2	3	4	Plus dollars for additional persons
Virginia:					
Group I	2,300	2,700	3,100	3,500	5—$3,900; 6—$4,300; 7—$4,800; 8—$5,300; 9—$5,800; 10—$6,400; $600 for each additional person.
Group II	2,500	3,100	3,400	3,800	5—$4,200; 6—$4,600; 7—$5,100; 8—$5,600; 9—$6,100; 10—$6,700; $600 for each additional person.
Group III	2,900	3,500	3,900	4,300	5—$4,800; 6—$5,300; 7—$5,800; 8—$6,400; 9—$6,900; 10—$7,400; $600 for each additional person.
Washington	2,772	3,948	4,500	5,268	5—$6,035; 6—$6,804; 7—$7,572; 8—$8,340; 9—$9,108; 10—$9,876; $64 for each additional person.
West Virginia	2,000	2,200	2,800	3,300	5—$3,800; 6—$4,300; 7—$4,800; 8—$5,400; 9—$6,000; 10—$6,600; $600 for each additional person.
Wisconsin	3,400	5,000	5,300	6,300	5—$7,200; 6—$7,800; 7—$8,400; 8—$9,000; 9—$9,400; 10—$9,600; $300 for each additional person.

[1] The following 20 States are not listed since they do not include the "medically needy" in the scope of the program: Alabama, Alaska, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Mississippi, Missouri, Nevada, New Jersey, New Mexico, Ohio, Oregon, South Carolina, South Dakota, Texas, and Wyoming.
[2] There are 5 additional district scales, ranging from $2,346 to $3,108 for a family of 1.

Source: Health Care Financing Administration, HEW.

Since 1965 when Medicaid was enacted, all States participating in the program have been required to provide certain basic medical services: inpatient and outpatient hospital services, physicians' services, laboratory and X-ray services, and skilled nursing facility services for individuals 21 and older. A State has been free, however, to limit the amount, duration and scope of these services, and to provide additional services. Additionally, since a State controls the level of reimbursement for all non-institutional services, the payment rate established by the State often has a significant effect on the actual availability of a covered service.

Finally, States have the option to cover a wide array of additional services in their Medicaid programs—drugs, prosthetic devices, clinic services, dental care, etc. With the exception of certain services provided for children or specified in the statute, if a service is included by a State in its Medicaid program, it must be available to everyone covered by the program.

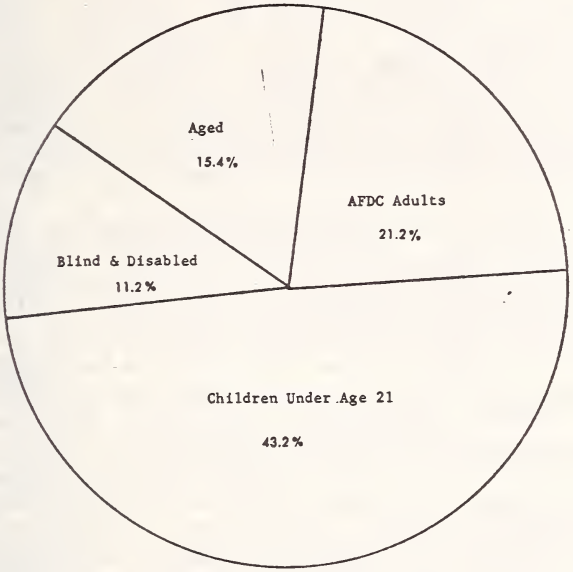
Although children make up a substantial portion of all persons receiving Medicaid services—they are over 40 percent of all Medicaid recipients—they account for a relatively small proportion of Medicaid expenditures, as demonstrated in the following table and charts.

MEDICAID RECIPIENTS AND EXPENDITURES BY ELIGIBILITY CATEGORY, FISCAL YEAR 1976

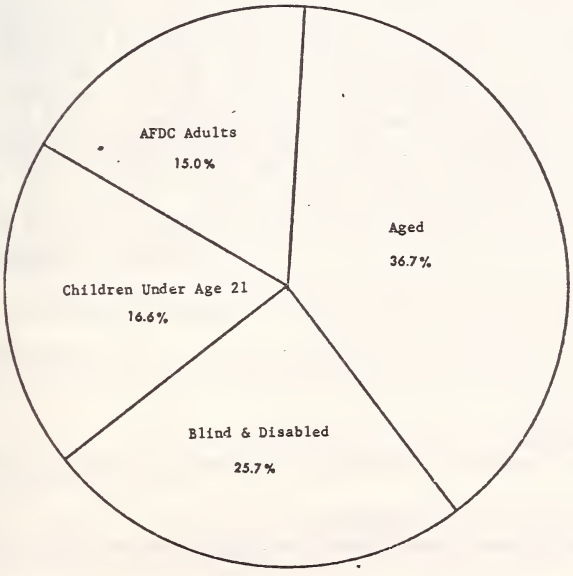
Basis of eligibility	Recipients		Expenditures	
	Total (in thousands)	Percent of total	Total (in millions)	Percent of total
	24,666	100.0	$14,135	100.0
Aged	3,807	13.4	5,191	36.7
Blind	98	.4	86	.6
Disabled	2,663	10.8	3,549	25.1
Children under age 21	10,644	43.2	2,352	16.6
Adults in AFDC families	5,238	21.2	2,244	15.8

Source: Office of Policy, Planning and Research, Research Report B-4 (fiscal year 1976), HEW.

MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976



MEDICAID EXPENDITURES BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976



B. The Existing Early and Periodic Screening, Diagnosis and Treatment Program

In 1967, a new mandatory service was added to Medicaid: the law was changed to provide that by July 1, 1969, all States had to offer early and periodic screening, diagnosis and treatment (EPSDT) services to individuals under 21 who are eligible under the State Medicaid program. This requirement signaled a change in the concept of Medicaid: it became more than simply a payment mechanism that financed services if an individual was successful in securing them. It gave the program responsibility actively to seek poor children in need of care, to assess their needs, and to see that the necessary service was received.

HEW delayed issuing final regulations to implement the EPSDT requirement until November 1971; regulations required implementation of EPSDT for children 0–6 by February 1972 and allowed delay in further implementation of EPSDT for all age groups until July 1, 1973. It is from that date until the present that EPSDT has been operational. However, partly because of the delay in the regulations, and partly because the State concerns that the program would be a burden on State budgets, implementation was slow. In 1972, the Congress added a provision to the law which provided that a State would be penalized by a reduction of 1 percent in the Federal matching rate for the AFDC program if it failed to inform all Medicaid-eligible families of the EPSDT program, failed to screen those who requested it, and failed to arrange for corrective treatment determined to be necessary. While substantial penalties have been assessed against the States, they have not actually been collected. HEW revised the regulations (effective October 1979) in order to make them more enforceable.

Much of the emphasis in the existing EPSDT program has been on screening, partly because of difficulties in developing tracking systems to allow measurement of whether children in need of treatment for conditions discovered during screening have actually received the necessary services. Even the performance of the program in providing screening services has been disappointing, however. Out of an estimated Medicaid population of about 11.0 million children, about 2.0 million received screening services in FY 1977 (resulting in about 3.0 million children with up-to-date assessments).

The legislation is not specific concerning EPSDT services. HEW regulations have set standards for a minimum screening package, including:

Health and development history (physical and mental);

Unclothed physical examination;

Provision of immunizations appropriate for age and health history;

Vision testing;

Hearing testing;

Laboratory procedures appropriate for age and population groups;

Assessment of nutritional status;

For children 3 years of age and over, direct referral to a dentist for diagnosis and treatment.

Each State must establish an appropriate periodicity schedule for screening.

The intent of EPSDT was not just to screen children, but to provide the services necessary to treat their health problems. However, under current law States were allowed to limit their treatment of detected illnesses to the services they provided under their State Medicaid plan for all Medicaid recipients, except that in all cases had to include "eyeglasses, hearing aids, and other kinds of treatment for visual and hearing defects, and at least such dental care as is necessary for relief of pain and infection and restoration of teeth and maintenance of dental health" for children who are screened and in need of those serviecs.

EPSDT has demonstrated the need for preventive care for poor children. According to HEW statistics

Over 50 percent of the children screened under EPSDT require referral for an average of two conditions per child;

Fifty percent of the children are inadequately immunized;

Nearly 10 percent of children in urban areas have elevated blood lead levels;

Ten percent of the children assessed have vision problems and 3 percent have hearing problems;

Twenty-five percent of the children are referred for treatment of severe dental problems.

Most evaluations of the EPSDT program have been critical of its general performance, however. The Subcommittee on Oversight and Investigations concluded in its report that although EPSDT has the potential for being the most important long-term, cost effective health care program currently in existence, that there were serious deficiencies: many children were not being screened, and perhaps more importantly, of those screened, in many cases, the program was unable to assure that treatment was received. Similar conclusions were reached in the report of the Children's Defense Fund on the program. Among the identified problem areas were these:

Many needy children were not eligible;

The on and off nature of eligibility for welfare and Medicaid interfered with receiving necessary services;

Many eligible children were never reached by the program;

The program often failed to link children to an ongoing source of health care;

In some areas there were inadequate numbers of providers for Medicaid children;

Follow-up to ensure that children received necessary services often did not occur.

C. Prenatal Care

A pregnant woman is covered under the current Medicaid program now:

(i) If she already has a dependent child, and because of the death, absence or unemployment of the father, she qualifies as a member of an AFDC family;

(ii) If she is under 21 and is either a child in an AFDC family or is in a State where all individuals under 21 are covered;

(iii) If she is a disabled person, or

(iv) If the State considers her to be a "family" on the basis of the unborn child. This is an option available to the States, but some 19 States have not exercised it.

The result is that many young, low-income women are unable to receive adequate pre-natal care. In some cases, it is because the woman is pregnant with her first child. Once the baby is born, the mother and child can often qualify for Medicaid coverage, but coverage is not available to provide necessary care before the baby is born. In other cases, where States do not cover members of intact families, and the woman has a husband in the home, neither eligibility for pre- or post-natal services is available.

This failure to provide coverage is of particular concern because prenatal care can effectively reduce the incidence of premature births, neonatal deaths, and other conditions associated with high risk pregnancies. The prevention of congenital defects can depend in large part on good prenatal care including proper immunization before pregancy and genetic counseling for those at risk.

Sound medical management can limit the possibility of harm to mother and infant due to the presence of chronic or acute illness in the pregnant woman. Morbidity and mortality among neonates is highly concentrated among those prematurely born or with intrauterine growth retardation. The majority of such births can be prevented and made normal by good prenatal care beginning before or during early pregnancy.

D. Other Limitations in Medicaid Coverage

Under current law, children removed from an AFDC family and placed in foster care are eligible for Medicaid. However, if these children are placed for adoption, their eligibility for Medicaid ceases unless the adopting family can qualify for Medicaid coverage. A substantial number of the children in foster care, estimated by HEW to be at least 100,000, suffer from handicapping conditions which require continuing care and treatment which raises the spectre of high medical bills. This fact, in combination with a likelihood of being declared ineligible for coverage under the adopting family's private health insurance policy because of the preexisting medical condition, serves as a severe fiscal disincentive to families considering adoption of these children. The result is many of these children remain in foster care at public expense, because of the inability to continue Medicaid coverage after adoption.

A second adverse effect on assuring adequate health care coverage to needy children results from a provision of current law which bans Medicaid payments for persons who are inmates in public institutions (except patients in medical institutions). The effect of this limitation is to deny medical assistance to juveniles who are in public child care facilities, halfway houses, detention facilities, and correctional institutions. Studies carried out in several States indicate as many as 70 percent of these young people may be poor enough to be eligible for Medicaid, but their detention in a public facility results in ineligibility for Medicaid.

A third aspect of the current Medicaid program which has resulted in children failing to receive coverage has been the effect of the inter-

pretations of the residency provisions by some States. While States are not allowed to impose durational residency requirements as a condition of Medicaid eligibility, some have required that the person have a legal and permanent home, or domicile, in the State. This interpretation has resulted in an inability to secure Medicaid coverage for many children in migrant families.

HEALTH STATUS OF AMERICAN CHILDREN

A. Introduction

This report presents an overview of existing data on the health status of American children. The overall health of an individual or population group is a difficult entity to define or quantify, though a group of selected indicators is generally used to develop a composite picture. These include mortality, morbidity, and health services utilization patterns.

While improvements have been registered in several of these key indicators in recent years, there are several areas in which the measures for non-white or low-income populations are not on a par with those for white and higher income groups. Mortality data for children and youth show significant variations by color. Both overall death rates and infant mortality rates are significantly higher for non-whites than whites. Related data show that black women are less likely than whites to receive prenatal care during the first two trimesters of pregnancy and are more likely to have infants of low birth-weight.

The information derived from leading morbidity indicators does not fall into a consistent pattern. Overall there are only moderate differences in the incidence of acute conditions for children in various income groups; however, the rate for whites is considerably higher than that recorded for non-whites. Poor children are more likely to suffer a limitation in activity attributable to a chronic condition than those in higher income categories; however there is little difference between whites and blacks in activity limitation attributable to such conditions. Children in low-income families have more restricted activity days, bed days, and school-loss days than those in higher income families. In general, white children experience more of these disability days than those of other races.

Children receive most of their medical care on an ambulatory basis. Those in low-income families tend to have slightly fewer physician contacts, substantially fewer dental visits, and higher hospitalization rates than those in higher income families. While black children are hospitalized less frequently than whites, they tend to have longer lengths of stay. Blacks also see physicians and dentists less frequently than white children. White children and those in higher income families tend to be more adequately immunized than their counterparts.

Children and youth experience more limitation as a result of acute respiratory conditions than for any other acute condition. Similarly, asthma is the primary chronic condition causing some activity limitation in this group. Approximately one quarter of all physician visits and one fifth of all days spent in short-stays hospitals for persons under age 18 are for respiratory conditions.

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B. Mortality

I. General

The death rate in the United States reached a record low in 1977—8.8 deaths per 1,000 population compared with 8.9 per 1,000 recorded in 1976. Death rates are usually lower for the white population than for people of other races from infancy through 75–79 years of age. The difference in death rates is particularly visible in the younger age groups. Table 1 illustrates this occurrence for age groups from infancy through 20-24 years. For example, for children under one year of age, children of other races had a recorded death rate of 25.5 per 1,000 population as compared to 12.7 per 1,000 population for white children. Males under one year of age in other racial groups recorded a death rate of 27.8 per 1,000 population. The death rate for white males that age was only 14.3 per 1,000 population. Further, in the 1-4 age category, other racial groups recorded a death rate of one per 1,000 population whereas the rate for white children was only .6 per 1,000 population.

TABLE 1.—DEATH RATES BY AGE, COLOR, AND SEX: UNITED STATES 1977

[Rates per 100,000 population]

	Total			White			All other		
	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female
Under 1 yr	1,485.6	1,659.0	1,303.5	1,266.2	1,429.7	1,094.8	2,546.4	2,780.4	2,304.5
1 to 4 yr	68.8	76.5	60.8	62.5	69.7	55.0	97.6	108.1	87.1
5 to 9 yr	34.0	40.6	27.1	32.1	38.4	25.6	43.0	51.6	34.3
10 to 14 yr	35.1	44.4	25.5	34.0	42.5	25.0	41.0	53.9	28.0
15 to 19 yr	101.6	145.7	56.4	101.2	145.8	55.2	103.9	145.0	62.8
20 to 24 yr	133.5	201.9	65.3	125.0	190.0	59.3	184.1	276.6	99.1

Source: Final Mortality Statistics, 1977 (Advance Report), Monthly Vital Statistics Report, NCHS, DHEW, p. 13.

Death rates declined for most age groups of both sexes between 1976 and 1977. However, certain age groups did not experience such a decline. These groups included males aged 10–25 years with an increase of 3.9 percent and females aged 10–24 years with an increase of 5.6 percent.[1]

Higher death rates among races other than white are reflected in Table 2 which lists the leading causes of death among children. The leading causes of death vary slightly among children, according to age, race, and sex. However, certain leading causes of death are found in all children. For instance, accidents are the leading cause of death for all children, aged 1–14 years. Children of races other than white recorded higher death rates for almost every leading cause of death. For example, these children experienced a higher death rate from accidents than did white children. Males of other races, aged 1–4years, recorded a rate of 42.9 deaths per 100,000 people, whereas white males of that age recorded a rate of 29.4 deaths per 100,000. Significant differences in death rates among races are also apparent in homicide as well as in influenza and pneumonia. In the 1–4 age group, males of other races experienced a rate of 6.0 deaths per 100,000 from influenza and pneumonia compared to a rate of 2.9 deaths per 100,000 for white males.

[1] Final Mortality Statistics, 1977 (Advance Report). Monthly Vital Statistics Report. National Center for Health Statistics, DHEW, May 11, 1979 ; p. 2.

TABLE 2.—DEATH RATES FOR LEADING CAUSES OF DEATH IN SPECIFIED AGE GROUPS, BY COLOR AND SEX: UNITED STATES 1977

[Rates per 100,000]

Causes of death	1 to 4 yr					5 to 14 yr				
	Male			Female		Male			Female	
	Total	White	All other	White	All other	Total	White	All other	White	All other
All causes	68.8	69.7	108.1	55.0	87.1	34.9	40.6	52.8	25.3	31.0
Accidents	(1)27.3	(1)29.4	(1)42.9	(1)20.8	(1)30.7	(1)17.3	(1)21.7	(1)30.8	(1)10.9	(1)12.4
Congenital anomalies	(2)8.8	(2)8.6	(2)9.7	(2)8.5	(2)10.4	(3)1.9	(3)1.9	(4)1.9	(3)1.7	(4)2.2
Malignant neoplasms, including neoplasms of lymphatic and hemopoietic tissues	(3)5.2	(3)6.2	(5)4.6	(3)4.5	(5)4.5	(2)4.8	(2)5.8	(2)4.8	(2)3.9	(2)3.7
Influenza and pneumonia	(4)3.1	(4)2.9	(4)6.0	(4)2.3	(4)4.8	(5).9	(6).9	(6)1.1	(4).9	(6)1.2
Homicide	(5)2.7	(6)1.9	(3)8.2	(5)1.6	(3)6.3	(4)1.2	(5).9	(3)2.9	(5).9	(3)2.4
Diseases of heart	(6)1.9	(7)1.7	(6)3.1	(6)1.6	(6)3.5	(6).9	(7).8	(5)1.2	(6).7	(5)1.5
Meningitis	(7)1.7	(5)2.0	(7)2.8	(7)1.3	(8)1.6		(9).3			(9).4
Cerebrovascular diseases	(8).8	(8).8	(10).8	(8).8		(8).5	(8).6	(8).6	(7).4	(7).4
Meningococcal infections	(9).7	(9).6	(10).8	(9).7	(9)1.1					
Enteritis and other diarrheal diseases	(10).6		(10).8	(10).6						
Septicemia		(9).6	(9)1.3							
Anemias			(8)1.9		(7)1.8	(10).3		(7).7	(10).2	(7).4
Acute bronchitis and bronchiolitis					(9)1.1					
Suicide						(7).5	(4)1.0	(9).4		
Benign neoplasms and neoplasms of unspecified nature						(9).3	(10).2		(8).3	(10).3
Bronchitis, emphysema and asthma								(9).4	(10).2	
Diabetes mellitus									(9).2	

Note: In the above table, death rates for various causes are listed 2d. These causes represent the 10 leading causes of death for each listed age category. The actual ranking of the cause of death is listed in parenthesis.

Source: DHEW, NCHS, unpublished data.

II. Infant Mortality

Infant mortality rates reflect a variety of health factors. Included among those factors are maternal health and nutrition, housing, the worth and availability of health care delivery systems, environmental hygiene, and even the average quality of life in a given population.[2]

Infant mortality rates in the United States do not compare favorably with rates in other selected industrialized nations. In comparison with 12 other industrialized countries in 1971 and 1976, the U.S. ranked tenth in infant mortality rates. Only the German Federal Republic, Italy and Israel recorded higher rates. In fact, even if the infant mortality rate for only the U.S. white population was used, the U.S. rate would still be higher than the rates in Sweden, the Netherlands, France, Switzerland, and Japan.[3]

TABLE 3.—INFANT MORTALITY RATES: SELECTED COUNTRIES, SELECTED YEARS 1971–76

[Data are based on national vital registration systems]

Country	Infant mortality rate (infant deaths per 1,000 live births)	
	1971	[1] 1976
Canada	17.6	14.3
United States	19.1	15.2
Sweden	11.1	8.7
England and Wales	17.5	14.0
Netherlands	12.1	10.5
German Democratic Republic	18.0	14.1
German Federal Republic	23.3	17.4
France	17.1	12.5
Switzerland	14.4	10.5
Italy	28.5	19.1
Israel	20.4	22.9
Japan	12.4	9.3
Australia	17.3	14.3

[1] Data for Canada and Australia refer to 1975.

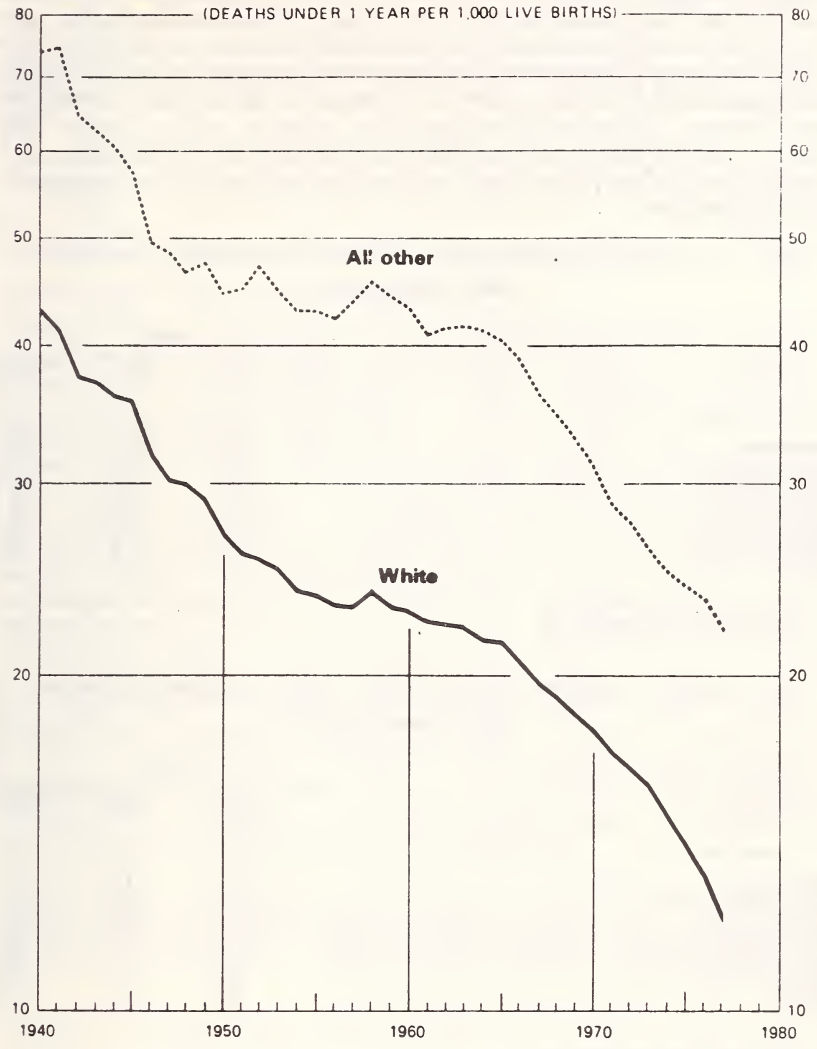
Note: Countries are grouped by continent.

Sources: United Nations: Demographic Yearbook 1974 and 1976, New York. United Nations, 1975 and 1977; World Health Organization: World Health Statistics, 1977, vol. 1. Geneva World Health Organization, 1977; World Health Organization: Selected data.

As indicated by the following chart the infant mortality rate for whites has been significantly lower over the years than the rate for other races. In 1977, the total U.S. infant mortality rate decreased to 14.2 per 1,000 infant deaths. However, the rate for whites in 1977 was 12.3 compared to 21.7 for other races. Consequently, the infant mortality rate for all other infants exceeded that of white infants by over 75 percent. In 1976, infant mortality rates for black babies were 92 percent higher than for white babies. The rate of death for black babies during the first seven days after birth was 87 percent higher. If the infant mortality rate for black babies had been similar to that of white babies in 1976, 6,280 more black babies would have lived.[4]

[2] Chase, Allan. America Falls Further Behind. Medical Tribune, Nov. 1, 1978: p. 6.
[3] Health, United States, 1978. Public Health Service, DHEW, December 1978. p. 168.
[4] Health, United States, 1978. Public Health Service, DHEW, December 1978, p. 50.

CHART 1. INFANT MORTALITY RATES BY COLOR: UNITED STATES, 1940–77



Source: Final Mortality Statistics 1977 (advance report), Monthly Vital Statistics Report, NCHS, DHEW, p. 10.

Tables 4 and 5 indicate that among regions, the South generally had the highest infant mortality and neonatal mortality (under 28 days) rates in the country in 1977. The South also ranked the lowest in per capita personal income in the country.[5] For poor children, the chances of dying in the first year of life were ⅔ greater than for those living

[5] Unpublished data, Bureau of Economic Analysis, Department of Commerce.

above poverty levels.[6] Among states, Mississippi recorded the highest resident infant mortality rate for 1977—18.2 deaths per 1,000 live births. The District of Columbia also had a high infant mortality rate. In fact, that rate increased from 25.3 to 27.4 infant deaths per 1,000 deaths between 1976 and 1977. Only four other states, Hawaii, Florida, Delaware, and Louisiana, saw an increase in their infant mortality rate during that same time span.[7] In contrast, states in the New England and Pacific Regions had much lower infant mortality and neonatal mortality rates. Those regions also ranked high in per capita personal income.

TABLE 4.—INFANT MORTALITY RATES BY COLOR: UNITED STATES, BY GEOGRAPHIC DIVISIONS, 1977

[Rates per 1,000 live births]

Division	Rates		
	Total	White	All other
United States	14.1	12.3	21.7
New England	11.8	11.3	19.1
Middle Atlantic	14.3	12.3	22.4
East North Central	14.3	12.5	23.4
West North Central	13.0	12.2	21.6
South Atlantic	15.8	12.6	23.0
East South Central	16.1	13.3	23.5
West South Central	15.3	13.1	23.2
Mountain	12.4	11.9	17.1
Pacific	12.1	11.6	14.4

Source: DHEW, NCHS, unpublished data.

TABLE 5.—NEONATAL MORTALITY RATES BY COLOR: UNITED STATES, BY GEOGRAPHIC DIVISIONS, 1977

[Rates per 1,000 live births]

Division	Rates		
	Total	White	All other
United States	9.9	8.7	14.7
New England	8.9	8.4	14.1
Middle Atlantic	10.6	9.3	15.8
East North Central	10.0	8.9	16.0
West North Central	9.6	9.1	14.9
South Atlantic	11.0	9.0	15.4
East South Central	11.1	9.4	15.6
West South Central	10.6	9.1	16.1
Mountain	8.0	7.8	10.0
Pacific	7.8	7.5	9.3

Source: DHEW, NCHS, Unpublished data.

[6] Report to the Congress by the Comptroller General of the United States. Early Childhood and Family Development Programs Improve the Quality of Life for Low-Income Families. Feb. 6, 1979 : p. 23.

[7] Final Mortality Statistics 1977 (Advance Report) Monthly Vital Statistics Report, NCHS. DHEW, p 9.

C. Prenatal Care

Prenatal care, the care a woman receives during pregnancy, plays a key role in increasing the number of live births. In 1977, the number of live births in the United States increased to approximately 3.3 million. This figure represents an increase over each year since 1972. However, it is still less than the 4.3 million live births recorded in 1960.

TABLE 6.—*Live births according to race: United States, 1977*

Race	*Live births*
Total	3,326,632
White	2,691,070
All other	635,562

Source: DHEW, NCHS Unpublished data, 1977.

Early initiation of prenatal care is considered vital to the health of the mother and child. Prenatal care provides the opportunity to identify and treat existing medical and obstetric problems, and educate the mother in regard to the proper nutrition and other aspects of the hygiene of pregnancy.[8] Women who are least likely to receive early prenatal care are most likely to have babies who are in poor health.[9]

Child health experts generally agree that prenatal care should begin during the first three months of pregnancy.[10] In 1977, almost 75 percent of women giving birth made at least one visit for prenatal care during the first trimester of pregnancy. However, at the same time, almost six percent of women received no prenatal care during either of the first two trimesters. The rate for black women receiving no care during the first two trimesters was double that for whites—9.6 percent vs. 4.7 percent. Black women as well as adolescent and older women are less likely than others to receive early prenatal care. In 1977, over 20 percent of women under the age of 15 received no prenatal care during the first two trimesters of pregnancy (White—22.9 percent, Black—19.9 percent). Of black adolescent women aged 15-19, almost 13 percent received no such care. In addition, approximately 13 percent of black women over 40 also received no prenatal care.

[8] Prenatal Care, United States, 1969–1975. National Center for Health Statistics, Public Health Service, DHEW, Sept. 1978 : 1.

[9] Health, U.S. 1978. Public Health Service, DHEW, December 1978 : p. 49.

[10] Report to the Congress by the Comptroller General of the United States. Early Childhood and Family Development Programs Improve the Quality of Life for Low-Income Families, Feb. 6, 1979 : p. 22.

TABLE 7.—LIVE BIRTHS, ACCORDING TO MONTH OF PREGNANCY PRENATAL CARE BEGAN AND RACE AND AGE OF MOTHER: UNITED STATES, 1977

Race and age of mother	Number of live births in reporting areas[1]	All live births (percent)	Month of pregnancy in which prenatal care began (percent)				
			1st or 2d	3d	4th to 6th	7th to 9th	No prenatal care (percent)
Total[2]	3,003,754	100.0	47.4	26.6	20.4	4.2	1.4
Under 15 yr	10,389	100.0	14.8	17.3	46.5	15.5	5.8
15 to 19 yr	504,995	100.0	28.6	25.4	35.3	8.1	2.6
15yr	27,940	100.0	19.5	21.1	43.4	12.1	3.9
16 yr	63,472	100.0	21.7	23.7	41.5	10.0	3.2
17 yr	101,909	100.0	25.4	24.7	38.4	8.7	2.8
18 yr	138,723	100.0	28.6	25.9	35.1	7.9	2.6
19 yr	172,951	100.0	34.4	26.9	30.0	6.5	2.2
20 to 24 yr	1,035,508	100.0	46.6	27.3	20.5	4.1	1.4
25 to 29 yr	917,360	100.0	56.1	26.6	14.0	2.5	.8
30 to 34 yr	403,307	100.0	54.9	26.6	14.8	2.7	1.0
35 to 39 yr	109,182	100.0	46.8	26.9	20.4	4.2	1.7
40 to 49 yr	23,013	100.0	36.9	26.4	26.8	6.8	3.0
White	2,425,741	100.0	50.2	27.1	18.0	3.5	1.1
Under 15 yr	4,236	100.0	15.2	18.3	43.6	16.7	6.2
15 to 19 yr	353,713	100.0	30.4	26.5	33.2	7.6	2.3
15 yr	15,271	100.0	20.5	22.0	41.5	12.2	3.8
16 yr	39,874	100.0	22.3	25.0	39.8	9.9	2.9
17 yr	69,738	100.0	26.4	25.6	37.0	8.3	2.6
18 yr	99,225	100.0	30.0	26.9	33.4	7.5	2.3
19 yr	129,605	100.0	36.4	27.7	28.0	5.9	1.9
20 to 24 yr	838,631	100.0	49.2	27.8	18.4	3.5	1.1
25 to 29 yr	782,512	100.0	58.0	26.8	12.5	2.1	.6
30 to 34 yr	341,415	100.0	56.8	26.8	13.3	2.3	.8
35 to 39 yr	87,491	100.0	48.9	27.1	18.7	3.8	1.5
40 yr and over	17,743	100.0	38.4	26.9	25.6	6.5	2.6
Black	495,747	100.0	34.4	24.6	31.4	6.8	2.8
Under 15 yr	5,980	100.0	14.5	16.8	48.8	14.5	5.4
15 to 19 yr	141,011	100.0	24.1	23.0	40.4	9.2	3.4
15 yr	12,153	100.0	18.2	20.0	46.0	11.7	4.0
16 yr	22,333	100.0	20.6	21.4	44.4	10.0	3.5
17 yr	30,190	100.0	23.2	22.7	41.5	9.3	3.4
18 yr	36,622	100.0	24.7	23.5	39.5	8.8	3.4
19 yr	39,713	100.0	28.1	24.4	36.4	8.2	3.0
20 to 24 yr	173,654	100.0	35.1	25.3	30.4	6.6	2.7
25 to 29 yr	107,345	100.0	43.7	25.4	24.0	4.8	2.1
30 to 34 yr	46,452	100.0	43.3	25.7	24.1	4.8	2.2
35 to 39 yr	17,023	100.0	36.3	25.8	28.9	6.1	3.0
40 yr and over	4,282	100.0	31.1	24.7	31.7	8.3	4.3

[1] In 1977, month of pregnancy during which prenatal care began was reported by 44 States and the District of Columbia.
[2] Includes all other races not shown separately.

Note: Percents are based only on records for which month of pregnancy prenatal care began is stated.

Source: DHEW, NCHS, unpublished data.

D. Birth-Weight

Weight at birth is related to a number of factors including gestational age, race, age of mother, weight gain during pregnancy, cigarette smoking, and socioeconomic status.[11] Low birth-weight increases an infant's chance of encountering developmental problems or even dying within the first year.[12] Physically and mentally crippling birth defects are three times as likely to occur among low birth-weight babies.[13]

Low birth-weight has been cited as consequence of inadequate prenatal care. For instance, reports indicate a lack of adequate prenatal care increases by threefold the chance that a baby will be born with

[11] Prenatal Care, United States, 1969–1975, op. cit., p. 19.
[12] Testimony of Leonard Schaeffer, Administrator of the Health Care Financing Administration, before the Senate Finance Subcommittee on Health, June 25, 1979: p. 13.
[13] America's Children 1976. National Council of Organizations for Children and Youth: 1976: p. 40.

low birth-weight. However, it is difficult to determine a direct association between prenatal care and birth-weight because access to prenatal care and the quality of prenatal care are related to many other variables.[14] A recent study, based on data compiled between 1969 and 1975, found that the likelihood of a low birth-weight outcome was more dependent on the mother's educational attainment than initiation of prenatal care.[15] Table 8 indicates that for the most part in 1977, mothers with more years of schooling delivered fewer low birth-weight babies. According to the data, only 6.1 percent of women who completed twelve years of schooling delivered infants of low birth-weight. In contrast, 9-10 percent of women with fewer completed school years gave birth to low-weight infants. In each education category, black women were more likely to deliver low birth-weight babies. For example, of those women with eight or less years of school, 15.1 percent of black women gave birth to low birth-weight babies as compared to an 8.3 percent figure for white women.

TABLE 8.—PERCENT OF INFANTS OF LOW BIRTH WEIGHT BY EDUCATION, AGE, AND RACE OF MOTHER, 1977 [1]

Years of school completed and age of mother	All births		
	All races	White	Black
All years of school:			
All ages	7.1	5.9	12.9
Under 15 yr	15.0	11.4	17.4
15 to 17 yr	11.0	8.8	15.0
18 yr	9.9	8.1	14.5
19 yr	8.8	7.0	14.4
20 to 24 yr	7.1	5.9	12.7
25 to 29 yr	5.8	5.1	11.0
30 to 34 yr	6.1	5.4	11.0
35 to 39 yr	7.8	6.8	12.8
40 yr or more	8.8	7.7	12.5
0 to 8 yr of school:			
All ages	9.7	8.3	15.1
Under 15 yr	14.7	11.3	17.2
15 to 17 yr	11.9	9.7	17.5
18 yr	10.8	9.8	16.1
19 yr	10.0	9.0	15.9
20 to 24 yr	9.1	8.3	13.7
25 to 29 yr	8.0	6.8	13.6
30 to 34 yr	8.3	7.3	13.3
35 to 39 yr	8.7	7.5	13.2
40 yr or more	10.0	9.2	13.3
9 to 11 yr of school:			
All ages	10.0	8.2	14.4
Under 15 yr	15.8	11.8	17.7
15 to 17 yr	11.0	8.8	14.9
18 yr	10.5	8.7	15.4
19 yr	10.0	8.3	15.2
20 to 24 yr	9.3	7.8	14.2
25 to 29 yr	8.8	7.4	13.0
30 to 34 yr	9.4	8.2	12.7
35 to 39 yr	11.3	10.4	12.9
40 yr or more	11.9	10.7	13.8
12 yr of school and over:			
All ages	6.1	5.2	11.6
Under 15 yr			
15 to 17 yr	9.5	7.4	13.2
18 yr	8.9	7.1	13.3
19 yr	7.9	6.0	13.8
20 to 24 yr	6.4	5.3	12.0
25 to 29 yr	5.4	4.8	10.2
30 to 34 yr	5.5	5.0	10.0
35 to 39 yr	6.9	6.1	12.4
40 yr or more	7.2	6.5	10.8

[1] Total of 35 reporting States and the District of Columbia.

Source: Unpublished data, National Center for Health Statistics, DHEW.

[14] Prenatal Care, United States, 1969–1975, op. cit., p. 19.
[15] Ibid., p. 3.

It has been reported that ten to 15 percent of babies born to lowest income families have low birth-weights. The figure for all families stands at only eight percent.[16] One determinant of low birth-weight babies is malnutrition of the mother, a condition which often begins in the woman's own youth. One-half (urban white) to two-thirds (urban black, rural white) of pregnant women in poverty are malnourished. In fact, in 1973, pregnant women on food stamps got less than two-thirds of the calories and protein needed for fetal development.[17]

E. Self-Assessment of Health

The health status of American children can be measured in several ways. One indicator is based on individual's assessments of their health compared to others in the same age group. In 1976, the perception of excellent health was characteristic of 58.8 percent of the population under age 17, and the perception of good health was characteristic of an additional 36.4 percent of this age group. Notable variations in self-assessment occurred by income category with 28.4 percent more children in the highest income category than in the lowest income category reported in excellent health.

TABLE 9.—SELF-ASSESSMENT OF HEALTH OF PERSONS UNDER AGE 17 ACCORDING TO SEX AND FAMILY INCO ME 1976

Sex and family income	Self-assessed level of health			
	Excellent	Good	Fair	Poor
Total	58.8	36.4	3.9	0.4
Sex:				
Male	59.2	36.2	3.8	.4
Female	58.4	36.6	4.0	.4
Family income:				
Less than $5,000	41.2	49.9	7.5	.8
$5,000 to $9,999	49.7	44.4	4.9	.6
$10,000 to $14,999	59.8	35.8	3.8	.3
$15,000 or more	69.6	27.4	2.4	.2

Source: DHEW, PHS, OASH, Health: United States, 1978, December 1978, table 55, p. 234.

F. Morbidity

The principal measures of health status are data related to morbidity. This information is collected during the annual Health Interview Surveys of the civilian noninstitutionalized population of the United States conducted by HEW. Included are national estimates relating to acute illnesses and injuries, chronic conditions, and disability. The following sections highlight the major findings from the 1977 report plus related findings from other sources.

I. *Acute Conditions*

(*a*) *Incidence.*—During 1977, an estimated 190.5 million acute illnesses occurred among the civilian noninstitutionalized population under age 17. The incidence rates of 385.6 per 100 persons per year for children under age six and 287.8 per 100 persons for children aged 6–16 were higher than for any other population group. Respiratory conditions accounted for 52 percent of all acute conditions for children aged

[16] America's Children, 1976, op. cit., p. 45.
[17] Ibid.

16 and under. Infective and parasitic diseases were the second most common acute condition for children under age 6, while injuries were the second most common for persons from 6–16 years old.

The 1977 incidence rate for all acute conditions was higher for girls aged 16 and under than for boys in the same age group. However, the incidence rate for injuries was considerably higher for boys than for girls.

TABLE 10.—NUMBER OF ACUTE CONDITIONS PER 100 PERSONS PER YEAR, BY AGE, SEX, AND CONDITION GROUP: UNITED STATES, 1977

[Data are based on household interviews of the civilian noninstitutionalized population]

Condition group	Number of acute conditions per 100 persons per year					
	Total		Male		Female	
	Under 6 yr	6 to 16 yr	Under 6 yr	6 to 16 yr	Under 6 yr	6 to 16 yr
All acute conditions	385.6	287.8	369.0	283.6	402.8	292.2
Infective and parasitic diseases	61.6	40.6	54.8	41.3	68.7	40.0
Respiratory conditions	200.6	148.2	198.9	136.2	202.3	160.7
Upper respiratory conditions	135.6	90.2	141.4	81.7	129.5	99.1
Influenza	47.8	50.5	39.9	47.5	56.0	53.6
Other respiratory conditions	17.2	7.5	17.6	7.1	16.8	8.0
Digestive system conditions	15.7	17.3	13.0	18.1	18.5	16.5
Inquiries	44.1	44.5	49.4	56.0	38.6	32.4
All other acute conditions	63.6	37.1	53.0	31.9	74.7	42.5

Note: Excluded from these statistics are all conditions involving neither restricted activity nor medical attention.

Source: DHEW, PHS, NCHS, "Current Estimates From the Health Interview Survey, United States—1977," September 1978, table 2, p. 12.

Overall, there are only moderate differences in the incidence of acute conditions for children in various income groups. In 1977, children in families with incomes of $5,000–$9,999 experienced the lowest rate of 3.16 conditions per person while those in families with incomes of $25,000 or more experienced the highest rate of 3.23 per person. The average for all groups was 3.18. Whites averages 3.36 acute conditions per person, considerably higher than the 2.28 per person rate recorded for non-whites.

TABLE 11.—INCIDENCE OF ACUTE CONDITIONS FOR CHILDREN UNDER AGE 17, BY INCOME LEVEL, 1977

[Number of acute conditions per person per year]

Conditions	Income level					
	All [1]	Under $5,000	$5,000 to $9,999	$10,000 to $14,999	$15,000 to $24,999	$25,000 and over
All acute conditions	3.18	3.22	3.16	3.30	3.18	3.23
Infective and parasitic diseases	.47	.39	.47	.50	.48	.52
Respiratory conditions	1.65	1.79	1.61	1.64	1.66	1.59
Upper respiratory conditions	1.04	1.16	1.04	1.14	.97	.96
Influenza	.50	.51	.46	.44	.57	.48
Other respiratory conditions	.11	.12	.11	.06	.12	.15
Digestive system conditions	.17	.14	.25	.19	.17	.13
Injuries	.44	.46	.43	.47	.43	.51
All other acute conditions	.45	.45	.44	.49	.43	.48

[1] Includes individuals whose family income is unknown.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

TABLE 12.—INCIDENCE OF ACUTE CONDITIONS FOR CHILDREN UNDER AGE 17 BY COLOR, 1977

Conditions	All	White	Nonwhite		
			All	Black	Other
All acute conditions	3.18	3.36	2.28	2.23	2.72
Infective and parasitic diseases	.47	.51	.26	.26	[1] 1.24
Respiratory conditions	1.65	1.72	1.28	1.22	1.77
Upper respiratory conditions	1.04	1.07	.90	.86	1.28
Influenza	.50	.55	.25	.25	[1] 1.25
Other respiratory conditions	.11	.10	.13	.11	[1] 1.24
Digestive system conditions	.17	.17	.15	.17	[2]
Injuries	.44	.48	.27	.28	[1] 1.18
All other acute conditions	.45	.48	.33	.31	.52

[1] Figure does not meet statistical standards of reliability.
[2] Quantity zero.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

(*b*) *Impact.*—The impact of acute conditions on children and youth can be seen in the number of days of restricted activity, days spent in bed and days lost from school. This population group experiences more limitations as a result of acute respiratory conditions than for any other cause. During 1977, respiratory conditions accounted for 54 percent of all restricted activity days due to acute conditions for persons under age 17, 59 percent of bed disability days for this age group, and 58 percent of all days lost from school.

During 1975–76, one quarter of all physician visits were for respiratory conditions. More than half of these visits were for acute upper respiratory conditions, and 15 percent of them were for bronchitis or asthma. Similarly, one-fifth of all days spent in short-stay hospitals were for respiratory conditions with one-third of these attributable to pneumonia.

TABLE 13.—DAYS OF RESTRICTED ACTIVITY PER PERSON PER YEAR ASSOCIATED WITH ACUTE CONDITIONS, BY AGE, SEX, AND CONDITION GROUP, 1977

	Both sexes		Male		Female	
	Under 6	6 to 16	Under 6	6 to 16	Under 6	6 to 16
All acute conditions	11.7	9.3	12.3	8.6	11.2	10.0
Infective and parasitic diseases	2.3	1.6	2.3	1.6	2.2	1.6
Respiratory conditions	6.6	4.9	7.0	4.4	6.1	5.4
Upper respiratory conditions	3.6	2.4	4.1	2.1	3.1	2.7
Influenza	1.8	2.0	1.6	1.8	2.1	2.2
Other respiratory conditions	1.1	.5	1.3	.5	.9	.4
Digestive system condition	.4	.4	[1]	.3	[1]	.4
Injuries	.7	1.4	.8	1.5	[1]	1.2
All other acute conditions	1.8	1.1	1.7	.8	1.8	1.4

[1] Figure does not meet statistical standards of reliability.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: "Current Estimates from the Health Interview Survey: United States—1977;" September 1978, table 5, p. 15.

TABLE 14.—DAYS OF BED DISABILITY PER PERSON PER YEAR ASSOCIATED WITH ACUTE CONDITIONS, BY AGE SEX, AND CONDITION GROUP, 1977

	Both sexes		Male		Female	
	Under 6 yr	6 to 16 yr	Under 6 yr	6 to 16 yr	Under 6 yr	6 to 16 yr
All acute conditions	5.2	4.6	5.5	4.4	5.0	4.8
Infective and parasitic diseases	1.1	.9	1.1	1.0	1.1	.8
Respiratory conditions	3.0	2.8	3.2	2.6	2.8	3.0
Upper respiratory conditions	1.4	1.3	1.7	1.1	1.1	1.4
Influenza	1.0	1.2	.9	1.2	1.2	+1.3
Other respiratory conditions	.6	.3	(1)	.3	(1)	(1)
Digestive system conditions	(1)	.1	(1)	(1)	(1)	(1)
Injuries	(1)	.3	(1)	.4	(1)	(1)
All other acute conditions	.8	.4	.7	.3	.8	.6

[1] Figure does not meet statistical standards of reliability.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: "Current Estimates from the Health Interview Survey: United States—1977;" September 1978, table 6, p. 16.,

TABLE 15.—DAYS LOST FROM SCHOOL PER PERSON (6 TO 16 YR) PER YEAR ASSOCIATED WITH ACUTE CONDITIONS BY SEX AND CONDITION GROUP, 1977

	Both sexes	Male	Female
All acute conditions	4.9	4.7	5.2
Infective and parasitic diseases	.9	.9	.9
Respiratory conditions	2.9	2.6	3.1
Upper respiratory conditions	1.4	1.3	1.6
Influenza	1.2	1.1	1.3
Other respiratory conditions	.3	.3	.2
Digestive system conditions	.2	.2	.2
Injuries	.4	.5	.3
All other acute conditions	.5	.4	.6

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: "Current Estimates from the Health Interview Survey: United States—1977;" September 1978, table 7, p. 17.

(*c*) *Injuries.*—During 1977, there were an estimated 42.4 children under age 6 and 42.7 children aged 6–16 injured per 100 population. The incidence rates for children were higher than those for other population groups with boys experiencing considerably higher rates than girls. The home was the primary location of accidents resulting in injuries to children under age 6.

While the incidence rate for injuries was considerably higher for children than for other population groups, the number of days of restricted activity resulting from such injuries was substantially lower.

TABLE 16.—NUMBER OF PERSONS INJURED AND DAYS OF RESTRICTED ACTIVITY ASSOCIATED WITH INJURY PER 100 PERSONS PER YEAR, BY AGE 1977

	Number injured per 100 persons per year	Days of restricted activity per 100 persons per year
Both sexes:		
Under 6 yr	42.4	59.5
6 to 16 yr	42.7	137.6
All ages	34.8	330.4
Males:		
Under 6 yr	47.5	65.6
6 to 16 yr	53.8	161.0
All ages	41.3	350.3
Females:		
Under 6 yr	37.1	[1]
6 to 16 yr	31.1	113.3
All ages	28.8	311.9

[1] Figure does not meet statistical standards of reliability.

Note: Excluded from these statistics are all conditions involving neither restricted activity nor medical attention. Data are based on household interviews of the civilian noninstitutionalized population.

Source: "Current Estimates from the Health Interview Survey: United States—1977," September 1978; tables 9 and 10 pp. 19–20.

II. Chronic Conditions

In 1977, 3.4 percent of the civilian non-institutionalized population under age 17 experienced some limitation in usual activities due to a chronic condition; 1.8 percent of this population experienced a limitation in a major activity due to such condition. The percentages of those with limitations were comparable for males and females.

TABLE 17.—PERCENTAGE DISTRIBUTION OF CHILDREN UNDER AGE 17 WITH LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITIONS, BY DEGREE OF LIMITATION AND SEX, 1977

	With activity limitation	With limitation in major activity	With no activity limitation
Total population under 17 yr	3.4	1.8	96.6
Males under 17 yr	3.6	1.9	96.4
Females under 17 yr	3.1	1.8	96.9

Note: Major activity refers to ability to engage in school or preschool activities. Data are based on household interviews of the civilian noninstitutionalized population.

Source: "Current Estimates from the Health Interview Survey: United States—1977;" September 1978; table 14, p. 24

Poor children were more likely to suffer a limitation in activity attributable to a chronic condition than those in higher income categories. However, little difference in activity limitation was recorded between white and black children.

TABLE 18.—PERCENT DISTRIBUTION OF CHILDREN UNDER AGE 17, WITH ACTIVITY LIMITATION DUE TO CHRONIC CONDITIONS, BY INCOME LEVEL, 1977

		Income level				
Limitation	All [1]	Less than $5,000	$5,000 to $9,999	$10,000 to $14,000	$15,000 to $24,999	$25,000 to and over
With activity limitation	3.4	4.9	3.5	3.4	3.2	2.8
With limitation in major activity	1.8	3.0	1.8	2.0	1.7	1.2
With no activity limitation	96.6	95.1	96.5	96.6	96.8	97.2

[1] Includes individuals whose family income is unknown.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

TABLE 19.—PERCENTAGE DISTRIBUTION OF CHILDREN UNDER AGE 17 WITH ACTIVITY LIMITATION DUE TO CHRONIC CONDITIONS, BY COLOR, 1977

	Color				
			Nonwhite		
Activity limitation	All	White	All	Black	Other
With activity limitation	3.4	3.4	3.3	3.5	[1] 1.2
With limitation in major activity	1.8	1.8	1.9	2.0	[1] .6
With no activity limitation	96.6	96.6	96.7	96.5	98.8

[1] Figure does not meet statistical standards of reliability.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

Asthma is the primary chronic condition causing some activity limitation in children; in 1976 this condition accounted for 20.1 percent of persons experiencing some limitation in activity. During the same

period, 6.9 percent of those with activity limitations were limited because of impairments of lower extremities and hips, 6.7 percent because of mental and nervous conditions, 5.2 percent because of hearing impairments and 3.7 percent because of visual impairments.

TABLE 20.—*Selected Chronic Conditions Causing Limitation of Activity in Persons Under 17 Years of Age, 1976*

Chronic condition	*Percent* [1]
Arthritis and rheumatism	[2] 1.0
Heart conditions	2.4
Hypertension without heart involvement	[2] 0.3
Diabetes	[2] 1.0
Mental and nervous conditions	6.7
Asthma	20.1
Impairments of back or spine	3.2
Impairments of lower extremities and hips	6.9
Visual impairments	3.7
Hearing impairments	5.2

[1] Percent of persons limited in activity because of specified condition.
[2] Figure does not meet statistical standards of reliability.

Source: Health: United States, 1978, Table 56, p. 237.

Data for 1971–72 showed that 12.2 percent of children aged 1–5 and 23.5 percent of those aged 6–19 had significant eye abnormalities. While a higher percentage of children aged 1–5 needing but not receiving treatment came from low-income families, the opposite was true for the population aged 6–19.

TABLE 21.—PERCENTAGE OF POPULATION WITH SIGNIFICANT EYE ABNORMALITY AND TREATMENT STATUS, ACCORDING TO AGE AND FAMILY INCOME: UNITED STATES, 1971–72

[Data are based on examination of a sample of the civilian noninstitutionalized population]

Treatment status and family income	All ages	1 to 5 years	6 to 19 years
With significant eye abnormality:			
All incomes [1]	39.2	12.2	23.5
Less than $5,000	49.3	18.2	29.3
$5,000 to $9,999	36.6	9.5	22.3
$10,000 or more	36.5	12.3	22.9
Needing treatment for eye abnormality:			
All incomes [1]	7.1	3.5	4.7
Less than $5,000	9.0	3.7	4.6
$5,000 to $9,999	6.8	3.2	4.9
$10,000 or more	6.3	3.6	4.2
Not receiving treatment:			
All incomes [1]	47.9	71.4	46.8
Less than $5,000	57.8	91.9	43.5
$5,000 to $9,999	48.5	62.5	38.8
$10,000 or more	42.9	72.2	50.0

[1] Includes unknown income.

Source: "Health United States, 1978," table 57, p. 238.

The National Center for Education Statistics [18] estimated that during 1974–75 there were almost 8 million handicapped children under age 19. The principal handicapping condition was speech impairments followed by learning disability, mental retardation, and emotional

[18] The information in this paragraph was reported in "Health: United States, 1978," page 54.

disturbance. The National Center for Health Statistics estimated that in the early 1960's approximately 25 percent of children age 6–11 had handicaps for which special educational resources were recommended particularly special training for slow learners (13 percent) and speech therapy (6 percent). The Foundation for Child Development found no change in the level of reported need in 1976 but an increase in the availability and use of resources. In the case of older children (aged 12–17), the National Center estimated that 14 percent had handicapping conditions in the late 1960's for which special educational resources were recommended. Principal resources required were remedial reading (6 percent) and special training for slow learners (5 percent).

III. Disability

There were an estimated 11.2 days of restricted activity per person per year under the age of 17 in 1977 as a result of both acute and chronic illnesses and injuries. For the same population group there were an average of 5.2 bed disability days and an average of 5.4 days lost from school per child in 1977. There figures represent increases over the rates recorded in 1972 of 0.6 restricted activity days, 1.0 bed disability days, and 0.4 days lost from school.

TABLE 22.—DAYS OF DISABILITY PER PERSON UNDER AGE 17; PER YEAR, BY SEX, 1977

[Data are based on household interviews of the civilian noninstitutionalized population]

	Restricted activity	Bed disability days	Days lost from school [1]
Total population under 17 yr	11.2	5.2	5.4
Males under 17 yr	11.1	5.1	5.2
Females under 17 yr	11.4	5.3	5.6

[1] Data reported for children aged 6 to 16.

Source: "Current Estimates from the Health Interview Survey: United States—1977." September 1978, tables 12 and 13, pp. 23–23.

Children in families with incomes under $5,000 have more restricted activity days, bed days, and school-loss days per person than those in the higher income categories. In general, the incidence rates decline as family income rises.

TABLE 23.—DAYS OF DISABILITY PER PERSON PER YEAR BY INCOME AND AGE, 1977

[Data are based on household interviews of the civilian noninstitutionalized population]

Income	Under age 6		Ages 6 to 16		
	Restricted activity days	Bed days	Restricted activity days	Bed days	School-loss days
All Incomes [1]	12.3	5.7	10.7	5.0	5.4
Less than $5,000	15.9	9.0	13.0	6.3	6.7
$5,000 to 9,999	11.3	5.8	11.4	5.3	5.8
$10,000 to 14,999	11.7	4.9	10.7	4.9	5.3
$15,000 to 24,999	12.2	5.1	10.6	4.9	5.1
$25,000 and over	12.1	4.7	9.9	4.3	4.7

[1] Includes individuals whose family income is unknown.

Source: 1977 Health Interview Survey; calculations from unpublished data.

In general, white children experienced more disability days per person in 1977 than children of other races. The only measure for which lower rates were recorded was that for bed days for children under age six.

TABLE 24.—DAYS OF DISABILITY PER PERSON PER YEAR BY COLOR AND RACE, 1977

Color	Under age 6		Ages 6 to 16		
	Restricted activity days	Bed days	Restricted activity days	Bed days	School-loss days
All persons	12.3	5.7	10.7	5.0	5.4
White	12.9	5.6	11.1	5.2	5.6
Other	9.9	6.2	8.6	4.0	4.6
Black	9.5	6.4	8.7	4.0	4.5
Other	[1] 12.7	[1] 5.1	[1] 7.6	[1] 3.8	[1] 5.0

[1] Figure does not meet statistical standards of reliability.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey, calculations from unpublished data.

G. Immunization Status

Immunizations against childhood diseases has been cited by many as one of preventive medicine's greatest successes.[19] However, recently the number of actual immunizations has begun to decline.[20] In part, this decrease can be attributed to the success of various immunization programs. Often, parents no longer feel the critical need to have their children immunized against infectious diseases whose incidence is occurring less frequently among the childhood population. Outbreaks of previously controlled epidemic childhood diseases, such as the diphtheria epidemic in San Antonio, Texas in the early 1970's, may be a consequence of the decline in immunizations.[21] This situation is further demonstrated by a recent upsurge in measles—1977 was the worst year for that disease since 1971. In 1976, an estimated 13.7 million children 13 years and under did not receive a measles immunization.[22]

Table 25 indicates the immunization and disease infection status of children. A significant portion of children were inadequately protected against disease in 1977. For instance, approximately 40 percent of the Nation's children aged 1–4 remained incompletely immunized against rubella, diphtheria, measles, and polio. Less than half of those children were immunized against mumps. In addititon, white children, for the most part, were more likely to be immunized than children of other races. Almost 65 percent of white children aged 1–4 years were protected against polio, but only 41 percent of children of other races received the same type of protection.

[19] Health, U.S. 1978, Public Health Service, DHEW, December 1978 : p. 29.
[20] Politics and Social Policy : Failures in Child Health Services, Yale Health Policy Project : August 1976 : p. 4.
[21] Ibid.
[22] Report to the Congress by the Comptroller General of the United States. Early Childhood and Family Development Programs Improve the Quality of Life for Low-Income Families, February 6, 1979 : p. 24.

TABLE 25.—IMMUNIZATION AND INFECTION STATUS OF CHILDREN, ACCORDING TO SPECIFIC DISEASE, COLOR AND AGE: UNITED STATES, 1977

[Data based on household interviews of a sample of the civilian noninstitutionalized population]

Color and age	Population in thousands	Percent of population								
		Measles		Rubella		DTP[1] vaccination		Polio vaccination		
		Infection	Vaccination	Infection	Vaccination	3 or more doses	0 doses	3 or more doses	0 doses	Mumps vaccination
Under 1 yr	3,204	0.7	7.0	1.9	7.2	27.0	27.3	19.4	35.1	4.1
1 to 4 yr	12,071	3.8	63.1	10.0	59.4	69.5	3.3	60.1	8.7	48.1
5 to 9 yr	17,080	9.3	75.5	18.0	70.5	76.0	1.6	69.9	4.7	55.4
10 to 12 yr	10,911			28.5	63.5	74.0	2.5			
10 to 13 yr	14,903	17.1	70.2							40.9
10 to 14 yr	19,026							62.8	7.0	
White:										
Under 1 yr	2,641	.5	6.5	1.9	6.8	28.9	25.7	21.6	32.8	3.9
1 to 4 yr	9,924	3.4	65.5	10.2	61.2	73.0	2.9	64.2	6.9	50.7
5 to 9 yr	14,166	8.4	78.7	18.5	72.5	79.3	1.2	73.4	3.7	57.5
10 to 12 yr	9,099			29.6	65.3	77.0	1.3			
10 to 13 yr	12,436	16.0	73.3							42.0
10 to 14 yr	15,900							65.4	5.9	
All others:										
Under 1 yr	563	1.7	9.3	2.1	9.0	18.5	35.0	9.0	45.7	4.7
1 to 4 yr	2,148	5.9	52.0	8.7	50.9	53.2	5.3	41.0	16.9	36.2
5 to 9 yr	2,914	13.7	59.8	15.6	60.6	60.2	3.3	53.1	9.6	45.3
10 to 12 yr	1,812			22.7	54.3	59.0	5.7			
10 to 13 yr	2,468	22.6	54.4							35.2
10 to 14 yr	3,126							49.2	12.5	

[1] Diphtheria-tetanus-pertussis.

Note: The proportions of the population ever infected or vaccinated are not mutually exclusive.

Source: U.S. Immunization Survey, 1977. Center for Disease Control, HEW.

Underimmunization particularly occurs among poor children. The following table indicates that the lowest rates of immunization and highest rates of infection are often found among children living in poverty areas. For instance, in the central cities of the Standard Metropolitan Statistical Areas (SMSAs), 69.7 percent of those children in nonpoverty areas were vaccinated against measles, but only 56.1 percent of the poverty area children received the same protection. Consequently, thirteen percent of children in those poverty areas were infected by measles compared to a ten percent infection rate for those children in nonpoverty areas.

TABLE 25.—IMMUNIZATION AND INFECTION STATUS OF CHILDREN, ACCORDING TO SPECIFIC DISEASE, AGE METROPOLITAN STATUS, COLOR AND POVERTY LEVEL: UNITED STATES, 1977

[Data based on household interviews of civilian noninstitutionalized population]

Metropolitan status, color and poverty level	DTP vaccination[1] (0 to 13 yr)			Polio vaccination (0 to 14 yr)			Mumps (1 to 13 yr)	
	Population (in thousands)	3 or more doses	doses	Population (in thousands)	3 or more doses	doses	Population (in thousands)	Vaccination
Central cities of SMSA	12,191	65.0	4.4	13,200	57.3	9.2	11,307	45.6
White	8,143	69.9	3.8	8,809	63.5	7.3	7,545	47.9
All other	4,048	55.2	5.8	4,391	44.8	13.0	3,762	40.9
Poverty area	3,052	56.5	7.0	3,280	47.8	11.3	2,806	36.5
Nonpoverty areas	9,139	67.8	3.6	9,920	60.4	8.5	8,501	48.6
Remaining areas of SMSA	18,723	73.9	3.1	20,389	65.5	7.0	17,504	53.3
Poverty areas	1,142	69.8	4.6	1,223	61.1	10.0	1,052	41.6
Nonpoverty areas	17,581	74.2	3.0	19,164	65.7	6.8	16,452	54.0

	Measles (1 to 13 yr)			Rubella (1 to 12 yr)		
	Population (in thousands)	Infection	Vaccination	Population (in thousands)	Infection	Vaccination
Central cities of SMSA	11,307	10.9	66.3	10,287	16.4	63.5
White	7,545	9.4	70.6	6,837	17.2	65.5
All other	3,762	13.9	57.0	3,449	14.6	59.6
Poverty areas	2,806	13.1	56.1	2,567	18.6	58.2
Nonpoverty areas	8,501	10.2	69.7	7,719	15.6	65.3
Remaining areas of SMSA	17,504	9.0	74.4	15,939	17.5	69.2
Poverty areas	1,052	10.9	66.5	955	25.4	64.5
Nonpoverty areas	16,452	8.9	74.8	14,484	17.0	69.5

[1] Diptheria-tetanus-pertusis.

Note: Population totals are different since they reflect different age categories.

Source: DHEW, Center for Disease Control.

Further inequities were found in the immunization of children. For example, in the San Antonio diphtheria epidemic, the poor and minorities suffered disproportionate effects. Twelve times as much disease occurred among the poor and brown as among the well-to-do and white.[23]

Recent cooperative immunization efforts of the Department of Health, Education and Welfare and the State and local health departments appear to be having a beneficial effect in reversing these trends.

[23] Politics and Social Policy: Failures in Child Health Services. Yale Health Policy Project. August 1976; p. 4.

H. Utilization of Services

Children receive most of their medical care on an ambulatory basis even though they use less ambulatory care than adults. Children in low-income families tend to have higher hospitalization rates, slightly fewer physician contacts, and substantially fewer dental visits than those in higher income families. While black children are hospitalized less frequently than whites, they tend to have longer lengths of stay. Blacks also see physicians and dentists less frequently than white children.

I. Hospital Stays

1. (*a*) *Hospitalization rates.*—Children under 17 are the least likely of all age groups to be hospitalized. In 1977, 95 percent of this age group had no short-stay hospital episodes compared with 89.6 percent for the population as a whole. The average length of stay for children was 5.6 days compared to 7.8 days for the entire population. Boys had more hospital discharges and longer average lengths of stay than girls.

TABLE 27.—NUMBER OF DISCHARGES PER 100 PERSONS (UNDER AGE 17): PER YEAR AND AVERAGE LENGTH OF STAY, BY SEX, 1977

[Data are based on household interviews of the civilian noninstitutionalized population]

	Both sexes	Males	Females
Number of discharges per 100 persons per year	6.4	7.1	5.6
Average length of stay	5.6	6.0	5.0

Source: "Current Estimates from the Health Interview Survey: United States, 1977;" September 1978, table 15, p. 25.

Significant variations occur in the utilization of hospital services by various income categories. Poor children have more hospital discharges, more days of care, and longer average lengths of stay than the higher income. While whites have higher discharge rates than other population groups they have fewer days of hospital care and shorter average lengths of stay.

TABLE 28.—NUMBER OF DISCHARGES PER 100 PERSONS PER YEAR FROM SHORT-STAY HOSPITALS, NUMBER OF DAYS OF CARE PER 100 PERSONS, AND AVERAGE LENGTH OF STAY FOR CHILDREN UNDER AGE 17 BY INCOME, 1977

[Data are based on household interviews of the civilian noninstitutionalized population]

	Discharges per 100 persons per year	Days per 100 persons	Average length of stay
All incomes[1]	6.4	35.6	5.6
Under $5,000	8.5	66.4	7.8
$5,000 to $9,999	7.1	38.0	5.4
$10,000 to $14,999	6.7	44.7	6.7
$15,000 to $24,999	6.1	29.2	4.8
$25,000 to and over	4.8	17.2	3.6

[1] Includes persons whose family income is unknown.

Source: 1977 Health Interview Survey; calculations from unpublished data.

TABLE 29.—NUMBER OF DISCHARGES PER 100 PERSONS PER YEAR FROM SHORT-STAY HOSPITALS; NUMBER OF DAYS OF CARE PER 100 PERSONS; AND AVERAGE LENGTH OF STAY FOR CHILDREN UNDER AGE 17 BY COLOR, 1977

[Data are based on household interview of the civilian noninstitutionalized population]

Color	Discharges per 100 persons per year	Days per 100 persons	Average lengty of stah
All children	6.4	35.6	5.6
White	6.5	30.6	4.7
Other races	5.8	60.7	10.5
Black	5.9	61.0	10.3
Other	[1] 4.7	[1] 57.7	12.4

[1] Figure does not meet statistical standards of reliability.

Source: 1977 Health Interview Survey; calculations from unpublished data.

(*b*) *Causes of hospitalization.*[24]—Diseases and conditions are the primary reason for the hospitalization of children. Of the 352 days of short-stay hospital care per thousand persons under 18 in 1975–76, 274 were for this reason, 65 for injuries, 14 for deliveries and 3 for examinations and observations without illness.

Hospital utilization patterns vary by age. Infants under one year spend more time in such facilities than older children. Excluding routine hospitalization at birth, there were 1,266 hospital days per year for each 1,000 infants during 1975–76. This high rate was attributable to long hospitalization of infants in distress at birth. The average length of stay of infants hospitalized for perinatal morbidity resulting from maternal conditions, difficult labor, birth injuries, etc. was 14.2 days. However, pneumonia was the leading cause of care for infants.

Respiratory conditions were also the most common reason for hospitalization of preschool children during 1975–76 accounting for 35 percent of total days; about one-third of these days were because of

Respiratory conditions were also the most common reason for hospitalization (16 percent of total days).

Injuries were the primary cause of hospitalization for elementary school children (25 percent for ages 6–11) and young adolescents (23 percent for ages 12–15). Respiratory conditions were still a major factor for hospitalization of those of elementary school age (19 percent) but less important for young adolescents (10 percent). For older adolescents, injuries and childbirth were the leading causes of hospitalization. These accounted for 22 percent and 16 percent respectively of total days for youths 16–17 years old. On any given day, 38 percent of the boys aged 16–17 were hospitalized because of injury and 27 percent of the girls were there because of childbirth.

(*c*) *Operations.*—In 1975–76, 40.7 operations per thousand were performed on persons under age 15. The highest rate of 8.5 per thousand was recorded for tonsillectomies, with or without adendoidectomies. This represents a significant drop from the rate of 16.2 per thousand recorded in the period 1965–66.

[24] The information in this section was reported in "Health : United States, 1978," pages 59–60.

TABLE 30.—OPERATIONS PER 1,000 POPULATION UNDER AGE 15 FOR INPATIENTS DISCHARGED FROM NON-FEDERAL SHORT-STAY HOSPITALS, ACCORDING TO SEX, AND LEADING SURGICAL CATEGORY, AVERAGE ANNUAL 1975–76

[Data are based on a sample of hospital records]

Leading surgical category	Both sexes	Male	Female
All operations [1]	40.7	46.4	34.7
Tonsillectomy with or without adenoidectomy	8.5	8.5	8.6
Myringotomy	3.9	4.5	3.4
Repair of inguinal hernia	2.0	3.4	.6
Closed reduction of fracture without fixation	1.9	2.4	1.4
Appendectomy [2]	1.8	2.0	1.7
Adenoidectomy without tonsillectomy	1.5	1.7	1.4
Resection and recession of eye muscle	1.0	1.0	1.0
Dilation of urethra	.9	[3].3	1.5
Excision of lesion of skin and subcutaneous tissue	.9	.9	.8

[1] Operations per thousand population.
[2] Limited to estimated appendectomies, excluding those performed incidental to other abdominal surgery.
[3] Figure does not meet statistical standard of reliability.

Source: DHEW, PHS, OSAH, Health: United States, 1978, table 108, p. 318.

II. Physician Visits

(*a*) *Number of visits.*—Children under 17 years old had an average of 4.1 physician visits per person per year in 1977 compared to 4.8 visits per person for all age groups. Males averaged 4.2 visits per year while females averaged 4.0 visits.

Comparisons with earlier data show significant changes in the use of physician services by poor children. In 1964, poor children (in families with incomes below $4,000) averaged 2.7 physician visits per year, while those in higher income families ($10,000 or more) averaged 5.1 visits per year. By 1977, the rate was 4.1 visits for poor children (in families with incomes below $5,000) and 4.5 visits for children in higher income families ($15,000 or more). In 1977, the lowest rate—3.4 visits per person—was recorded for the near poor.

TABLE 31.—*Number of physician visits per child (under age 17) per year by family income, 1977*

All incomes	4.1
Less than $5,000	4.1
$5,000–$9,999	3.4
$10,000–$14,999	4.1
$15,000–$24,999	4.4
$25,000 and over	4.6

NOTE.—Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

Black children averaged 1.4 fewer physician contacts per year than their white counterparts in 1977. Similarly, children of other races averaged .7 fewer visits than whites.

TABLE 32.—*Number of physician visits per child (under age 17) per year by color, 1977*

All persons	4.1
White	4.3
Other	2.9
Black	2.8
Other	3.6

NOTE.—Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

(*b*) *Time interval since last physician visit.*—According to the 1977 Health Interview Survey, the majority of children had seen a physician within the preceding year. However, 25.1 percent of the population had not had a physician contact in the last year, approximately 1.8 percent had gone over five years, and 0.3 percent had never had a physician visit.

TABLE 32.—PERCENTAGE DISTRIBUTION OF CHILDREN (UNDER 17 YR) BY TIME INTERVAL SINCE LAST PHYSICIAN VISIT, ACCORDING TO SEX, 1977

	Both sexes	Male	Female
Time interval:			
Under 6 mo	56.9	57.2	56.5
6 to 11 mo	18.0	17.9	18.1
1 yr	14.0	14.0	14.0
2 to 4 yr	8.2	8.1	8.3
5 yr and over	1.8	1.7	2.0
Never	.3	.2	.3
Unknown	.9	.9	.8

Note: Data are based on household interviews of the civilian noninstitutionalized population.
Source: "Current Estimates from the Health Interview Survey: United States, 1977"; September 1978, table 21, p. 31.

In 1977, 88.7 percent of the population under age 6 had seen a physician in the last year. The rates ranged from a low of 86.6 percent of children in families with incomes of $5,000–$9,999 to a high of 92.5 percent of children in families with incomes of $25,000 and over. Whites were slightly more likely than other persons to have seen a physician during the period.

TABLE 34.—PERCENTAGE OF CHILDREN UNDER AGE 6 BY TIME INTERVAL SINCE LAST PHYSICIAN VISIT, ACCORDING TO INCOME LEVEL, 1977

	Income level					
Time interval	All incomes [1]	Less than $5,000	$5,000 to $9,999	$10,000 to $14,999	$15,000 to $24,999	$25,000 and over
Under 6 mo	75.8	74.8	73.8	76.2	76.7	80.6
6 to 11 mo	12.9	12.3	12.8	12.8	14.1	11.9
1 yr	7.2	7.9	8.7	7.3	5.9	4.7
2 to 4 yr	2.7	3.1	3.1	2.8	1.8	[2] 1.4
5 yr and over	([2,3])	([4])	([2,3])	([4])	([2,3])	([4])
Never	.4	[2] .7	[2] .5	[2] .2	[2] .3	[2] .1
Uninown	1.1	[2] 1.2	1.1	[2] .8	1.2	[2] 1.3

[1] Includes individuals whose family income is unknown.
[2] Figures does not meet statistical standards of reliability.
[3] Quantity less than 0.05.
[4] Quantity zero.

Note: Data are based on household interiews of the civilian noninstitutionalized population.
Source: 1977 Health Interview Survey; calculations from unpublished data.

TABLE 35.—PERCENTAGE OF CHILDREN UNDER AGE 6 BY TIME INTERVAL SINCE LAST PHYSICIAN VISIT, ACCORDING TO COLOR, 1977

			Nonwhite		
Time interval	Total	White	Total	Black	Other
Under 6 mo	75.8	76.4	72.8	72.3	76.0
6 to 11 mo	12.9	12.9	12.9	12.8	13.6
1 yr	7.2	6.7	9.6	9.9	[1] 7.2
2 to 4 yr	2.7	2.6	3.1	3.0	[1] 3.2
5 yr and over	([2])	([1,2])	[1] .1	[1] .1	([3])
Never	.4	.4	[1] .3	.4	([3])
Unknown	1.1	1.0	1.2	[1] 1.4	([3])

[1] Figure does not meet statistical standards of reliability.
[2] Quantity less than 0.05.
[3] Quantity zero.

Note: Data are based on household interviews of the civilian noninstitutionalized population.
Source: 1977 Health Interview Survey; calculations from unpublished data.

Children aged 6–16 are less likely than their younger counterparts to see a physician within the preceding year. In 1977, 68.6 percent of this group had such a contact. The rates ranged from a low of 63.4 percent for children in families with incomes of $5,000–$9,999 to 75.2 percent for those in families with incomes of $25,000 or more. Whites were slightly more likely than other persons to have seen a physician during the period.

TABLE 36.—PERCENTAGE OF CHILDREN AGED 6 TO 16 BY TIME INTERVAL SINCE LAST PHYSICIAN VISIT, ACCORDING TO INCOME LEVEL, 1977

Time interval	Income level					
	All incomes [1]	Less than $5,000	$5,000 to $9,999	$10,000 to $14,999	$15,000 to $24,999	$25,000 and over
Under 6 mo	48.4	47.5	44.5	47.6	49.8	53.3
6 to 11 mo	20.2	17.3	18.9	20.3	21.4	21.9
1 yr	17.0	17.4	18.4	17.6	16.2	14.5
2 to 4 yr	10.7	11.9	13.4	10.1	10.4	8.6
5 yr and over	2.6	4.8	3.5	3.4	1.7	.9
Never	.2	[2] .3	.5	[2] .3	([3])	([4])
Unknown	.8	[2] .7	.7	.7	.5	.8

[1] Includes individuals whose family income is unknown.
[2] Figure does not meet statistical standards of reliability.
[3] Quantity less than 0.05.
[4] Quantity zero.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

TABLE 37.—PERCENTAGE OF CHILDREN AGED 6–16 BY TIME INTERVAL SINCE LAST PHYSICIAN VISIT, ACCORDING TO COLOR, 1977

Time interval	Color				
			Nonwhite		
	Total	White	Total	Black	Other
Under 6 mo	48.4	49.3	43.9	43.7	46.1
6 to 11 mo	20.2	20.4	19.5	19.5	18.9
1 yr	17.0	16.4	19.9	20.3	16.4
2 to 4 yr	10.7	10.7	10.7	10.4	13.7
5 yr and over	2.6	2.3	4.2	4.3	[1] 3.2
Never	.2	.2	[1] .3	[1] .3	[1] .5
Unknown	.8	.7	1.4	1.4	[1] 1.2

[1] Figure does not meet statistical standards of reliability.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

(*c*) *Source of place of care.*—In 1977, children under age 17 had 245,107,994 physician visits. Of these, 62.9 percent were in doctors' offices, 14.7 percent were to hospital outpatient departments (outpatient clinics or emergency rooms); 16.9 percent were by telephone, and 5.4 percent were in other locations (company clinic, the home, and other and unknown sources or places of care).

The place where children receive physician care varies by income and color. Whites and the high income are more likely than other groups to obtain such care in a doctor's office. Hospital outpatient

departments are used more frequently by the low-income and nonwhites than by their counterparts.

TABLE 38.—PHYSICIAN VISITS, ACCORDING TO SOURCE OR PLACE OF CARE AGE, FAMILY INCOME, AND COLOR: UNITED STATES, AVERAGE ANNUAL 1975–76

[Percent of visits]

	Source or place of care			
	Doctor's office[1]	Hospital outpatient department[2]	Telephone	Other[3]
Under 18 yr:				
Family income:				
Less than $5,000	55.8	23.0	11.1	10.1
$5,000 to $9,999	57.4	20.7	13.3	8.6
$10,000 to $14,999	65.1	12.5	18.3	4.1
$15,000 or more	67.1	9.3	20.0	3.6
Color:				
White	65.3	11.9	18.2	4.6
All other	50.9	29.1	8.5	11.5

[1] Includes private doctor's office, doctor's clinic, or group practice.
[2] Includes hospital outpatient clinic or emergency room.
[3] Includes company clinic, home, and other and unknown sources or places of care.

Note: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

Source: DHEW, PHS, OASH, "Health: United States, 1978," December 1978, table 75, p. 270.

Pediatricians, general practitioners, and family practitioners provide the majority of private care for children.[25] Visits to pediatricians accounted for 40 percent of visits to office-based physicians during 1975–76; an additional 34 percent of visits were to general practitioners and specialists in family practice. While pediatricians accounted for 57 percent of the visits to office-based physicians by preschoolers this percentage declined to 23 percent for adolescents aged 12–15 and 7 percent for those 16–17 years.

(*d*) *Reasons for visits to office-based physicians.*[26]—Respiratory conditions accounted for 26 percent of all visits by children to office-based physicians during 1975–76. Routine care represented another 25 percent of such visits. The majority of the remaining visits were attributable to infectious and parasitic conditions (8 percent), skin conditions (7 percent), conditions affecting the nervous system (11 percent) and injuries (8 percent).

The reasons for and frequency of visits to office-based physicians change as an individual moves from infancy through adolescence. Infants under one year averaged 5.9 visists a year in 1975–76. Half of these were for routine care, 13 percent for acute upper respiratory conditions, 7 percent for infectious and parasitic conditions, 6 percent for ear conditions, and 2 percent for injuries. Older preschool children visited a doctor's office 2.4 times a year. Only quarter of the visits were for routine care. Acute upper respiratory conditions accounted for 21 percent of the visits, ear conditions for 12 percent and injuries for 6 percent. The average number of visits declined to 1.5 per person and the proportion of visits for routine care decreased to less than

[25] The material in this paragraph was reported in "Health: United States, 1978," page 59.
[26] The material in this section was reported in "Health: United States, 1978," page 59.

one-fifth for children aged 6–15. Injuries were a primary reason for taking a schoolboy to the doctor accounting for 11 percent by elementary schoolboys and 16 percent of those aged 12–15. While boys have more visits than girls through age 15, principally because of injuries, this changes in later adolescence. For girls 16–17, 11 percent of all visists are for prenatal care.

III. Dental Visits

Children visited the dentist on the average of 1.5 times per year in 1977. Boys averaged 1.4 visits while girls averaged 1.6 visits. Approximately 29.5 percent of children under age 17 had never seen a dentist. An additional 1.6 percent had not seen a dentist in over 5 years and 6.5 percent had gone 2–4 years without a dental visit.

TABLE 39.—PERCENTAGE DISTRIBUTION OF CHILDREN (UNDER 17 YR) BY TIME INTERVAL SINCE LAST DENTAL VISIT, ACCORDING TO SEX, 1977

Time interval	Both sexes	Male	Female
Under 6 mo	36.6	36.1	37.2
6 to 11 mo	14.4	14.2	14.7
1 yr	10.5	10.8	10.3
2 to 4 yr	6.5	7.1	6.0
5 yr and over	1.6	1.7	1.5
Never	29.5	29.4	29.5
Unknown	.8	.8	.8

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: "Current Estimates From the Health Interview Survey: United States, 1977," September 1978, table 19, p. 29.

The utilization of dental services differs considerably between children under age six and their older counterparts. Younger children averaged only 0.5 visits per year in 1977 while those aged 6 and over averaged 2.0 visits. An estimated 74.2 percent of younger children had never seen a dentist while only 9.7 of the older group had not had such a contact.

The utilization of dental services by children differs substantially among income groups. Poor children average fewer visits and longer time intervals between visits than children in higher income categories. Further, while only 9.7 percent of all children aged 6–16 had never seen a dentist, 17.9 percent of those in poor families and 16.8 percent of those in near poor families had not had such a contact. Similarly, blacks had fewer dental visits, longer periods between visits and a higher number of persons never seeing a dentist than whites.

TABLE 40.—NUMBER OF DENTAL VISITS PER PERSON UNDER AGE 17 PER YEAR, BY AGE AND INCOME, 1977

	Under 17	Under 6 yr	6 to 16 yr
All incomes	1.5	0.5	2.0
Less than $5,000	.8	[1].3	1.1
$5,000 to $9,999	1.0	.3	1.3
$10,000 to $14,999	1.3	.4	1.7
$15,000 to $24,999	1.8	.8	2.2
$25,000 and over	2.5	.9	2.9

[1] Figure does not meet statistical standards of reliability.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: "Current Estimates from the 1977 Health Interview Survey: calculations from unpublished data.

TABLE 41.—NUMBER OF DENTAL VISITS PER PERSON UNDER AGE 17 PER YEAR BY AGE AND COLOR, 1977

	Under 17 yr	Under 6 yr	6 to 16 yr
All persons	1.5	0.5	2.0
White	1.7	.5	2.2
Nonwhite	.9	.5	1.1
Black	.7	.4	.9
Other	2.1	[1] 1.2	2.6

[1] Figure does not meet statistical standards of reliability.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

TABLE 42.—PERCENTAGE OF CHILDREN UNDER 6 YEARS OF AGE BY TIME INTERVAL SINCE LAST DENTAL VISIT ACCORDING TO INCOME LEVEL, 1977

		Income level				
Time interval	All [1]	Less than $5,000	$5,000 to $9,999	$10,000 to $14,999	$15,000 to $24,999	$25,000 and over
Under 6 mo	15.9	11.9	10.7	13.9	20.4	27.9
6 to 11 mo	5.4	4.3	4.3	5.3	6.1	8.3
1 yr	3.4	2.2	3.6	3.9	3.0	3.5
2 to 4 yr	.8	[2] 1.4	1.0	[2] .8	[2] .6	[2] .8
5 yr and over	([2, 3])	[2] .1	([4])	([4])	([4])	([4])
Never	74.2	79.9	80.2	75.8	69.4	59.2
Unknown	.3	.2	[2] .2	[2] .2	[2] .4	[2] .3

[1] Includes persons whose family income is unknown.
[2] Figures does not meet statistical standards of reliability.
[3] Quantity less than 0.05.
[4] Quantity zero.

Note: Data are based on household interviews of the civilian noninstitutionlized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

TABLE 43.—PERCENTAGE OF CHILDREN UNDER 6 YR OF AGE BY TIME INTERVAL SINCE LAST DENTAL VISIT, ACCORDING TO COLOR, 1977

			Nonwhite		
Time interval	All	White	All	Black	Other
Under 6 mo	15.9	16.7	12.4	11.8	17.4
6 to 11 mo	5.4	5.6	4.0	3.6	[1] 7.4
1 yr	3.4	3.4	3.3	3.3	[1] 3.3
2 to 4 yr	.8	.7	1.6	1.6	[1] .4
5 yr and over	([1, 2])	([1, 2])	([3])	([3])	([3])
Never	74.2	73.3	78.4	79.3	71.5
Unknown	.3	.3	[1] .4	[1] .5	([3])

[1] Figure does not meet statistical standards of reliability.
[2] Quantity less than 0.05.
[3] Quantity zero.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

TABLE 44.—PERCENTAGE OF CHILDREN AGED 6 TO 16 BY TIME INTERVAL SINCE LAST DENTAL VISIT, ACCORDING TO INCOME LEVEL, 1977

		Income level				
Time interval	All incomes [1]	Less than $5,000	$5,000 to $9,999	$10,000 to $14,999	$15,000 to $24,999	$21,000 and over
Under 6 mo	45.9	34.4	32.9	40.7	51.9	62.4
6 to 11 mo	18.5	15.2	16.1	19.1	20.9	17.9
1 yr	13.7	15.4	16.1	15.4	12.9	9.7
2 to 4 yr	9.1	12.5	13.3	10.6	7.2	5.0
5 yrs and over	2.3	3.5	3.9	2.8	1.5	2.0
Never	9.7	17.9	16.8	10.6	4.9	2.6
Unknown	1.0	1.1	.9	.7	.7	1.4

[1] Includes persons whose family income is unknown.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; Calculations from unpublished data.

TABLE 45.—PERCENTAGE OF CHILDREN AGED 6 TO 16 BY TIME INTERVAL SINCE LAST DENTAL VISIT, ACCORDING TO COLOR, 1977

Time interval	All	White	Nonwhite		
			All	Black	Other
Under 6 mo	45.9	49.1	29.0	27.3	45.3
6 to 11 mo	18.5	18.4	18.8	18.6	20.4
1 yr	13.7	13.2	16.6	17.6	7.5
2 to 4 yr	9.1	8.4	12.4	12.2	14.1
5 yr and over	2.3	2.0	3.7	3.8	[1]2.4
Never	9.5	7.7	18.4	19.3	9.9
Unknown	1.0	1.0	1.1	1.1	[1].5

[1] Figure does not meet statistical standards of reliability.

Note: Data are based on household interviews of the civilian noninstitutionalized population.

Source: 1977 Health Interview Survey; calculations from unpublished data.

In addition to income, geographical residence also plays a role in the frequency of dental visits. Children residing in fringe counties of Standard Metropolitan Statistical Areas (SMSA's) have the highest number of dental visits per person while those in areas not adjacent to SMSA's have the fewest number.

TABLE 46.—*Dental visits of children under age 18 according to selected characteristics, average annual 1975–76*

	Dental visits per person
Geographic region:	
Northeast	1.7
North Central	1.7
South	1.2
West	1.8
Location of residence: [1]	
Within SMSA	1.7
Large SMSA	1.8
Core counties	1.7
Fringe counties	2.1
Medium SMSA	1.6
Other SMSA	1.3
Outside SMSA	1.3
Adjacent to SMSA	1.3
Not adjacent to SMSA	1.2

[1] Grouped according to the April 1973 Office of Management and Budget metropolitan-nonmetropolitan designations.

Source: Health: United States, 1978, Table 97, p. 300.

In 1971–74, 16.6 percent of children aged 1–5, 63.5 percent of those aged 6–11 and 67.5 percent of those aged 12–17 needed dental care. The primary need was for repair of decayed teeth. Those in lower income categories were more likely to require services than those in higher income groups.

TABLE 47.—PERSONS 1 TO 17 YR OF AGE NEEDING DENTAL CARE, ACCORDING TO AGE AND FAMILY INCOME: UNITED STATES, 1971–74

Family income	Age (percent)		
	1 to 5 yr	6 to 11 yr	12 to 17 yr
Total [1]	16.6	63.5	67.5
Less than $5,000	21.2	73.8	77.8
$5,000 to $9,999	19.2	71.0	77.5
$10,000 to $14,999	13.6	62.2	61.5
$15,000 or more	8.4	43.3	54.5

[1] Includes individuals whose family income is unknown.

Note: Data are based on dental examinations of a sample of the civilian noninstitutionalized population.

Source: Health: United States, 1978, table 64, p. 248

TABLE 48.—PERCENTAGE OF PERSONS 1 TO 17 YR OF AGE NEEDING DENTAL CARE, ACCORDING TO AGE AND SELECTED NEEDS: UNITED STATES, 1971–74

Selected dental needs	Age (percent)		
	1 to 5 yr	6 to 11 yr	12 to 17 yr
Cleaning	2.4	28.2	27.5
Gingivitis treatment	[1].1	1.9	13.4
Periodontal treatment	[1].2	[1].1	2.0
Decayed tooth repair	16.1	52.7	53.6
Extractions	[1].8	[1].4	[1].6
Fixed bridges and/or partials	(1)	[1].1	5.8
Denture or bridge repair	(1)	(1)	[1]0
Full denture construction	(1)	[1]0	[1].1

[1] Figure does not meet statistical standards of reliability.

Note: In the 1st 3 categories only, sample persons who had an indicated need for all 3 appear only in the peridontal treatment group. Those with an indicated need for cleaning and gingivitis treatment appear only in the gingivitis group. Those with an indicated need for cleaning only appear only in that group. Data are based on dental examinations of a sample of the civilian noninstitutionalized population.

Source: Health, United States, 1978, table 63, p. 248.

IV. Long-Term Institutional Care

In 1976, there were approximately 152,000 children under age 18 in institutions designed for medical or protective care. This represents a rate of 2.3 persons institutionalized per thousand. The rate was higher for nonwhites (3.2 per thousand) than whites (2.1 per thousand). The types of facilities these individuals were in included nursing homes, facilities for the mentally retarded, homes for dependent children, homes or resident schools for the emotionally disturbed, and resident facilities for drug abusers or alcoholics. Excluded from these figures are long-stay hospitals and penal and/or juvenile detention facilities.

Medical reasons accounted for 37.9 percent of all admissions to institutions followed by family reasons (30.6 percent) and commitment or assignment to a facility (14.4 percent). Mental retardation was the most common reason for medical admissions and accounted for 12 percent of all children in institutions. Nervous disorders and mental illness accounted for an additional 11 percent of admissions.

The institutionalized population requires a broad range of medical therapy and educational services; however, not all of the persons requiring treatment actually receive it.

TABLE 49.—SERVICES NEEDED AND RECEIVED BY THE INSTITUTIONALIZED POPULATION UNDER AGE 18 ACCORDING TO AGE AND TYPE OF SERVICE, 1976

Type of service	Percent of population needing specified services	Percent of those needing services who are receiving them [1]
Medical	49.7	57.9
Nursing	44.8	94.7
Psychiatric	32.3	68.9
Physical/speech therapy	30.1	75.4
Occupational therapy	14.1	70.2
Educational training	76.7	98.4
Social work	60.3	80.8
Other services	41.0	94.6

[1] Receiving services at least once a month.

Note: Excludes persons in long-stay hospitals and penal and/or juvenile detention facilities. Data are based on reporting by staff in a sample survey of institutions.

Source: Health: United States, 1978, table 113, p. 326.

NEED FOR AND BENEFITS OF ADEQUATE PRENATAL CARE AND HEALTH CARE FOR CHILDREN

Focusing prevention and comprehensive health care on children has the greatest potential for reducing morbidity and mortality and the greatest potential for cost benefits due to increased length and quality of life. The value of early detection is important to prevent future disability. Yet estimates indicate that as many as 10 million children in the United States receive no health care whatsoever, and 20 million children under 15 years of age are not adequately immunized. 25 percent of all women giving birth do not have at least one prenatal visit during the first trimester of pregnancy, and among teenagers under 15 years of age who become pregnant, seven out of ten receive no prenatal care during the first trimester, and one-fourth receive no prenatal care at all.

Nearly 11 million children in families with income of less than 150 percent of the poverty level are not eligible for Medicaid coverage. Even among the 12 million children who are Medicaid eligible and who should therefore have access to medical care, many severe health care problems exist, either undetected or untreated. The early experience with the EPSDT program has demonstrated this: Overall data from the program show that over 50 percent of children screened require referral for an average of two conditions per child. 50 percent are inadequately immunized, nearly 10 percent in urban areas had elevated blood lead levels, and large numbers of dental, hearing, and vision problems exist. Even under the inadequate dental screening system of the current program, about 25 percent of children have dental problems requiring care (some estimates indicate the real need for treatment may be as high as 90 percent).

The benefits from preventive services and continuous care can be high. One recent nationwide survey indicated a drop in hospitalization of 20 percent for persons in organized care settings. EPSDT experience shows that the number of conditions needing treatment drops substantially once a child has been initially assessed and given care; health status improves. Some States have even experienced relatively dramatic decreases in costs of Medicaid services per child once children were screened and come under continuous care.

The cost benefit of prenatal care is also well documented. Mothers with no prenatal care are three times more likely to give birth to infants with low birth weights, which is associated with almost half of all infant deaths and substantially increases the likelihood of birth defects. The prevention of mental retardation from biologic causes also relates principally to good prenatal care; retardation is highly concentrated among low-birth weight and premature babies. Today, the Medicaid program spends nearly $1 billion a year to provide institutional services for the mentally retarded. A decline in the need for this institutional care would result in significant program savings.

The inclusion of coverage of prenatal care for low income pregnant women by all state Medicaid programs would have a significant and positive effect on the health of children and would bring considerable cost savings in the long run.

Prenatal care helps prevent fetal and neo-natal health problems and prematurity, conditions strongly associated with birth defects, mental retardation, and later health and developmental problems. For example, one extensive study found that prematurity rates among mothers who made their first prenatal visit in the first trimester averaged 6.5% while prematurity rates averaged 23.6% among mothers who made no visits at all.

Adequate prenatal care reduces the particularly high incidence of problems associated with teenage pregnancy: problems such as toxemia of pregnancy and premature labor as well as low birth weight. These are responsible for a variety of health problems in infants and children.

Despite the dramatic benefits of prenatal care, women who are most likely to have complications in their pregnancy are the least likely to receive early prenatal care. For example, seven out of ten mothers under 15 years of age receive no prenatal care during the first trimester while one-fourth never receive any prenatal care or delay receiving it until the end of pregnancy. Low income women, particularly, go without needed prenatal care. During 1975, while 69.4% of all U.S. women began prenatal care in the first trimester, only 53.8% of all Black women began prenatal care during the first trimester. Furthermore, 5.8% of all women in the U.S. received no care or received care only in the final trimester while 9.9% of all Black women were in this category.

The necessity of adequate prenatal care for the future health of a child is unquestionable.

The Children's Defense Fund and the Department of Health, Education, and Welfare have provided the Committee with specific examples of the benefits of early detection and continuous care. The Department reports that

> Focusing prevention and comprehensive health care on children has the greatest potential for reducing morbidity and mortality and the greatest potential for cost benefits due to increased length and quality of life. The value of early detection is important to prevent future disability.

In Baltimore, physicians from the University of Maryland screened 361 children; of those screened, 335 had referrable conditions, in their view "not one of these conditions would otherwise have been recognized so early in its course" without the program.

Overall data from the program show that 55 percent of children screened require referral for an average of two conditions per child. These problems are either newly detected or were known to families but not under medical treatment.

Reduce Utilization of Acute Care Services.—Preventive services and continuous care—especially when delivered in a comprehensive setting—can result in lower hospitalization.

In Title V Children and Youth Projects, hospital days decreased up to 40 percent as comprehensive preventive and followup care was delivered.

The Portsmouth, Virginia Health Department studied Medicaid costs for AFDC beneficiaries in three adjacent census tracts over two

years. One area had personal outreach, physical exams and counselling; the second physical exams and the third neither. Those with physical exams, counselling and outreach had an 8 percent decrease in hospital days; those with physical exams only experienced a 5 percent increase; those with neither a 17 percent increases in hospital days.

In Boston, Massachusetts, among families randomly assigned to a comprehensive care program, there was a significant increase in the receipt of preventive services and a substantial reduction in laboratory costs, prescription medications, hospitalizations, and illness visits.

In a study in Boston, low-income families treated by a comprehensive, family focused pediatric health care team had fewer operations and hospitalizations than a group of low-income families without access to such service.

In Michigan, where children are on the second cycle of EDPST screening, the rate of referrals for problems found through screening dropped from those returning for rescreening; the referral rate declined overall by 13 percent.

Reduce Health Care Expenditures.—Benefits from screening and other preventive services extend beyond fulfilling the need for such services and reducing the need for more costly care such as hospitalization. Although the data is limited, isolated studies have shown that costs for screened children can be lower.

In North Dakota, total expenditures under Medicaid were compared for children who had been screened and those who had not. Per capita expenditures were 36–44 percent lower for those screened than for unscreened children.

The same study demonstrated that expenditures for inpatient hospital services for screened children were 47–48 percent lower than those for non-screened children.

In the Portmouth, Virginia Health Department study cited above, costs increased 50 percent for the group with no preventive care. Total cost for those children provided a full package of preventing services including outreach, physical examinations and counselling, increased by only 17 percent."

Another potential benefit derives from the fact that individuals who have their own identifiable health care provider are more apt to seek early attention for acute medical problems than those without an identified provider. The implications of this are important not only for the individual's health care but for its effect on health care costs.

Butler and Scotch of Harvard University have reported that a sizable body of evidence suggests that the Medicaid program has had a significant positive impact on rates of utilization of medical services among poor children, and has worked to reduce the average difference in use rates between poor and affluent children. The table shows a clear increase in physician visits by poor children between 1967 and 1975 which was especially pronounced from 1969 to 1971, a period of rapidly expanding Medicaid eligibility. Data from subsequent years suggest that in simple quantitative terms the average use rates of the Medicaid group are now comparable to those of affluent children. After 1974, differences in use rates between Medicaid-eligible children and children from near-poor families appear to have increased considerably.

PHYSICIAN VISITS PER CAPITA PER YEAR FOR ALL AGES AND UNDER 17 YR OF AGE BY INCOME: UNITED STATES FISCAL YEAR 1967, CALENDAR YEARS 1968–78

	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978
All ages:												
Under $5,000	4.3	4.5	4.6	5.0	5.6	5.5	5.7	5.6	6.0	5.9	6.0	6.1
$5,000 to $9,999	4.2	3.9	4.0	4.4	4.7	4.6	4.8	5.0	5.1	4.9	5.0	5.1
$10,000 to $14,999	4.5	4.2	4.2	4.6	4.7	4.9	4.9	4.6	4.8	4.8	4.6	4.6
$15,000 plus	4.8	4.5	4.5	4.9	5.1	5.4	5.1	4.9	4.9	4.8	4.6	4.5
All income[1]	4.3	4.2	4.3	4.6	4.9	5.0	5.0	4.9	5.1	4.9	4.8	4.8
Under 17 yr:												
Under $5,000	2.7	2.9	2.8	3.4	3.8	3.5	3.9	3.7	4.6	4.0	4.1	4.1
$5,000 to $9,999	3.8	3.4	3.4	3.6	3.9	3.7	3.8	3.7	3.9	3.4	3.6	3.8
$10,000 to $14,999	4.1	3.7	4.1	4.2	4.3	4.2	4.3	4.2	4.1	4.2	4.1	4.1
$15,000 plus	4.7	4.2	4.4	4.5	5.0	4.9	4.6	4.7	4.5	4.5	4.5	4.3
All income[1]	3.6	3.4	3.5	3.9	4.2	4.0	4.2	4.1	4.2	4.0	4.1	4.1

[1] Includes unknown income.

Note: Data are based on household interviews of the civilian, noninstitutional population.

Source: Unpublished data from the health interview survey, National Center for Health Statistics, Department of Health, Education, and Welfare.

The Harvard Child Health Project (Toward A Primary Medical Care System Responsive to Children's Needs, Report of the Harvard Child Health Project Task Force; Ballinger Publishing Co., Cambridge, Mass., 1977) also reviewed the importance of and benefits accruing from early detection and continuing care. Two illustrative examples from that study, iron-deficiency anemia and middle ear infections, further support the benefits of such care.

Among other significant findings, the Harvard Child Project reports that anemia is the most common blood disease among infants and children in the United States. Large-scale surveys indicate that 14 percent of all children are anemic and that iron deficiency is the cause of this condition in the great majority of cases. As the most widespread nutritional deficiency in the United States, it has its highest incidence among lower-income groups in both rural and urban areas. Iron-deficiency anemia presents no particular problem in diagnosis; hemoglobin tests yield excellent results. Nor is there doubt about the efficacy of supplementation therapy.

Justification for the treatment of symptom-free iron deficiency anemia depends upon evidence that failure to treat it has untoward consequences. Good evidence on this is scant but accumulating. Webb and Oski showed that scholastic performance in anemic twelve-to-fourteen-year-olds is inferior to that of controls in the same school. Joynson and colleagues reported a defect in cell-mediated immunity in adults with iron deficiency, although the adequacy of the control group in this study is questionable. The complexity of the relationship between the iron-deficient state and resistance to infection is indicated by Weinberg, who argues that low blood iron may provide a host advantage in resisting the invasion of microbes. Macdougall and colleagues reported impaired immune responses in iron-deficient children; after treatment with iron, these responses returned to normal.

The implication of these findings for Medicaid eligible children (where EPSDT studies have shown anemia to be one of the most common findings among screened individuals) is clear.

The Harvard Project further reports that middle ear infection is one of the most common ailments of childhood, particularly in children under ten years of age. It is the third leading reason for visits to pediatricians, after well-child care and immunization. Some 75 percent of all middle ear infections are self-limiting, and antibiotics have made such severe complications as mastoiditis rare. Notwithstanding, middle ear infections account for an estimated 50 percent of all hearing loss in childhood. Its role as a major factor in learning problems and poor educational progress has been recognized since the time of pioneering studies in Britain in the 1930's.

The Health and Nutrition Examination Survey (U.S. National Health Survey Series 11, No. 114) provided information both on the relationship of age to abnormalities of the ear on otoscopic examination and on the relationships between history of ear problems, otoscopic examination, and hearing testing in children six to eleven. One child in five was reported to have a history of earache, one in eight a history of running ear, and one in twenty-five trouble in hearing. The prevalence of these findings was not higher in older children than in younger ones. Children with a history of ear problems were significantly more likely to have abnormalities of the tympanic membrane and lower sensitivity (poor hearing) on audiometric testing than other children. The lack of change in prevalence with age, from six to eleven, indicates that much or most of the damage is probably done before the child reaches school age.

The incidence and prevalence of otitis media in the U.S. is difficult to pinpoint. We do know that in Great Britain about one-half of all children have experienced at least one episode of supurative otitis media by age eight and, five to ten years after the initial episode as many as 17 percent are suffering loss of hearing. The incidence of serous otitis media and its sequelae are difficult to appraise because that form of the disease is often asymptomatic but that is widely viewed as the most frequent cause of hearing loss in children.

There have been several critical reviews of studies to determine the relationship of middle ear infections and hearing loss to educational programs. All have concluded that hearing loss is related to poor school achievement, even when the loss is mild.

Obviously, the importance of early detection and treatment for these conditions, both for the individual and for society, cannot be overemphasized.

Committee Proposal

GENERAL COMMITTEE INTENT

The primary purpose of the legislation is to increase the availability of quality health care for low income children. The aim of The Child Health Assurance Program is to enroll children in a program of health care which preferably provides continuing health care within their community, and at a minimum provides comprehensive preventive services and needed subsequent care. The legislation also corrects the most serious deficiencies in Medicaid eligibility policies and benefits for children and pregnant women.

ELIGIBILITY FOR CHILDREN

The reported bill establishes a uniform minimum nationwide income standard for coverage of children under the Medicaid program, assures the eligibility of needy children under 18 for Medicaid in all States regardless of the structure of the family of which the child is a member, provides for reasonable continuity of eligibility for children on Medicaid, makes provision for a child to retain Medicaid eligibility while in a public institution for juveniles, allows Medicaid coverage for hard-to-place adopted children, and specifies the Secretary's authority to clarify residency standards so that children in migrant families and others who have been the subject of disputes between the States concerning residency are covered.

The Committee has long been impressed during on-going reviews of the Medicaid program with the deficiencies in program coverage of various individuals. Despite the perception of Medicaid as a program which provides health care for the poor, in fact many clearly needy persons are not eligible for coverage in many States because they do not fit into the "categories" of people who are covered under the welfare programs. The seriousness of this omission in coverage was underlined during hearings on the child health assurance proposals. In too many States, children in intact families were ineligible for Medicaid coverage. Further, the great variation in income standards among the States has resulted in extremely poor children being without medical care coverage. The lack of access to early preventive and continuing care, the Committee believes, results in a person who will be less healthy throughout his lifetime, resulting in more lost school and work days, higher use of institutional care, and in the end more medical expenses.

The Committee concluded that steps should be taken to make the Medicaid program an assured source of care for all needy children throughout the country.

Coverage of Children to 18

The reported bill requires all State Medicaid programs to extend eligibility to children who are determined to be needy regardless of whether that child is alone, is in a broken family, is in a family with an unemployed parent, or is in an intact family.

The Committee considered various alternatives for the requirements concerning the age to which children must be covered. Current law requires only that children who are members of AFDC-type families be covered, but within that narrow framework, they must be covered if they receive AFDC (or would if they were in school) up to the age of 21. In determining the priorities for expenditures of funds, the Committee determined that in general a State should be required to cover a child only up to the age of 18. If a State includes in its AFDC program children up to 21, then the requirement of Medicaid law that all persons receiving an AFDC payment be eligible for medical assistance would continue to govern. Thus, the minimum coverage group becomes, in the reported bill, children up to the age of 18 and children over 17 and under 21 to whom the State has, at its own option, provided an AFDC payment.

Eighteen States now provide Medicaid to all needy children under 21, however. It was not the intention of the Committee to require any reduction of coverage for this group; in fact, throughout its deliberations the Committee was intent on assuring that the legislation result in expansions of coverage, not cutbacks (see the section on maintenance of effort). Therefore, the reported legislation specifically allows any State to provide coverage for needy children up to the age of 21. If a State elects this option, Federal matching will be available for all medical assistance provided. The Committee expects that if the State opts for this broader coverage, the children between 17 and 21 brought into coverage would be eligible for the same services and under the same conditions as children under 18 covered under the State plan.

The Committee was aware that some States might desire to extend coverage to certain groups of individuals over 17 and under 21 without including all such individuals. The reported bill responds to this by allowing States to opt to cover all needy individuals under 21, or all needy individuals under 18, and reasonable classifications of individuals over 17 and under 19, 20 or 21. The Committee took this action to allow States flexibility. However, to prevent arbitrary classifications which are difficult to administer and discriminate against groups of children, the Committee expects reasonable classifications to include those categories currently used under Medicaid. These include, for example, children in foster care, children in psychiatric hospitals and children in intermediate care facilities. Additionally, the Committee would find reasonable a classification which allows coverage of those children between 17 and 21 who were covered by the State plan before enactment of this law, i.e., children between 18 and 21, in AFDC-type families who are not actually receiving an AFDC payment but would except for the requirements of section 406(a) (2) of the Social Security Act, for example.

Minimum Income Standard

After examining the substantial variation in the income eligibility standards applied by the States, the Committee determined that it was appropriate to take a step toward a uniform minimum nationwide income standard. The reported bill establishes such a standard at two-thirds of the nonfarm income official poverty line, which is defined by the Office of Management and Budget and revised annually. The standard is established for various family sizes, and the standard corresponding to the size of the child's family would be used in determining CHAP eligibility. This would result in an estimated income standard of approximately $5,000 for a 4-person family in 1980. Although establishment of such a minimum income level for Medicaid eligibility for children would represent a relatively sizeable increase in some States, the Committee believes this change in fact represents only a modest step in assuring adequate health care. This standard is used only for purposes of providing medical care to children. It will not add to the welfare roles or make adults in these families eligible for Medicaid. Establishment of such a level adds about 900,000 newly eligible children to the 4.1 million children estimated by the Congressional Budget Office to gain Medicaid eligibility because of the requirement that all children be included, regardless of family status.

It should be noted that the Committee intends that the national CHAP income standard, as established in Section 1902(d), be a minimum floor. Any state opting to use an income standard higher than the national floor for purposes of determining the Medicaid eligibility of a family with dependent children will receive federal reimbursement for services provided under CHAP and other Medicaid provisions.

Coverage of CHAP-eligible children is mandatory under state Medicaid programs. CHAP children are to be treated like other mandatory eligible groups with regard to program policies such as minimum benefits covered and cost sharing. The Committee intends that all CHAP-eligible children, regardless of whether they qualify for Medicaid through cash assistance programs or through the CHAP income standard, are given the most generous benefits and cost sharing policies to which Medicaid entitles them. In the 33 states which presently offer Medicaid coverage through a medically needy program, children who could qualify for Medicaid under CHAP or the medically needy program should be brought in under the program which provides them the most extensive coverage.

In establishing the minimum income level, the Committee attempted to adopt policies which would minimize the additional administrative burden of determining eligibility for this population. First, it allowed the resources standard used for families in the State Medicaid program to be retained. This is normally the standard used in the State AFDC program, but if a more generous standard is currently applied in the Medicaid program, the Committee would expect that standard to be used. In states with medically needy programs, for example, resource standards must be at least equal to the more generous of the AFDC resource standard or the SSI resource standard. It is not the intent of the Committee to place restrictions on the resources standard currently in use by a State is subject to legitimate criticism for being too generous, and it is not the intent to block the resources standard of any State from being liberalized. The Committee bill simply requires that whatever resources standard is normally used for families in the rest of the Medicaid program be applied for children who gain eligibility because of the minimum income standard as well.

The Committee also believes that the CHAP policy on disregards should be easily administered and make eligible for Medicaid the neediest low income children. The reported bill specifies that disregards currently used in determining eligibility under part A of Title IV be applied in CHAP, including income and expenses which are disregarded at state option under Title IV–A. In no cases should CHAP income policies be more restrictive than each State's current AFDC policies. The intent is to treat children brought in under the minimum income standard in a uniform manner with other children in the program and to minimize differences which would complicate the administration of the program.

Continuation of Eligibility

The reported bill provides that any Medicaid child who loses Medicaid eligibility for any reason other than attaining the maximum age of coverage for children under the state plan will be entitled to an additional four months of eligibility under Medicaid. For instance, the extension will apply to children whose family income or resources in-

crease because of increased hours of or increased income from employment. The Committee believes this provision can eliminate many of the problems of children going on and off Medicaid eligibility which has in the past complicated program administration burdened providers, and resulted in children not receiving the care their health assessments have shown to be necessary. The Committee notes that for children in AFDC families, this extension of eligibility would operate in place of, not in addition to the four-month extension of eligibility for AFDC families who would otherwise lose eligibility because increased income, resources, or hours of employment.

The bill provides that for children with conditions which cannot be corrected but can be ameliorated or controlled with proper diagnosis and treatment, such as epilepsy or diabetes, eligibility is extended for one year following the date when the child would otherwise lose eligibility, rather than for the more-limited four month period available for all children. It is the intent of the Committee that the 12-month extension of eligibility would be available to children with disabling medical conditions which are either physical or mental in nature. This extension of eligibility is to allow adequate time for development and implementation of an appropriate treatment plan which will stabilize the condition and hopefully bring it under control.

For example, a child with a developmental disability may require a variety of medical and related services which, if given early, can reduce later dependency by substantially mitigating attendant handicaps. Such services may include but are not limited to medication, physical therapy, occupational therapy, speech therapy, prosthetic devices and corrective surgery. In the case of a child with epilepsy, appropriate treatment with the proper drugs, might bring the condition under control.

Finally, the bill provides for an extension of eligibilty for children with a medical condition which is correctable. If the child, during the period of eligibility is found to have a medical condition which is usually thought to be correctable through medical or surgical treatment, which is certified by two qualified providers and for which a plan of treatment is submitted to the single State agency, eligibility for medical assistance will continue until the plan of treatment is completed or the child reaches 18 years of age, whichever comes first. The State may require prior authorization or professional review procedures which would determine the reasonableness and appropriateness of the plan of treatment. The State may not, however, withhold payment for services which are generally considered as necessary and appropriate by the professional medical community.

Coverage of Children in Public Institutions

The Committee was concerned that its intent to provide good health care to all needy children would be contradicted by the provision of current law which stops Medicaid coverage for persons who become inmates of public institutions that are not medical institutions. This provision results in denial of Medicaid to children who are in State operated homes, detention or correctional facilities, halfway houses and the like. This population has been estimated to number over 120,000 children who are in public institutions during some part of a

year, as many as 70 percent of whom come from families with income low enough to qualify for Medicaid. Health care in these public institutions is notoriously poor. The Committee believes it is appropriate to allow Medicaid coverage to continue for these children if they are in a public institution for juveniles, and either were eligible for Medicaid when they entered the facility or would have been eligible if they remained in the family.

Hard-to-Place Adopted Children

The reported bill allows Medicaid coverage for children with special needs placed for adoption. The Committee was concerned with the effect that results from the provision of the current Medicaid program which allows a State to cover children in foster care, but does not allow coverage if these children are placed for adoption in a family with income even slightly higher than the Medicaid standard.

HEW estimates that there are at least 100,000 children currently lingering in foster care who have not been adopted because of their special needs. A large number of these children have handicapping conditions—often multiple handicaps—which require continuing care and treatment. Although often eligible for Medicaid which in foster care, these children frequently would lose such eligibility if adopted and probably would also be ineligible for coverage under the insurance policies of adoptive parents because their handicaps constitute a preexisting condition. The absence of Medicaid coverage for such children following placement for adoption serves as a fiscal disincentive to finding permanent adoptive homes for these children and keeps them in foster care at public expense. The purpose of allowing States to cover these adopted children with special needs under Medicaid is to encourage and facilitate their adoption.

It should be noted that the decision whether to cover these children would be the state's. The Committee further gives states the option of limiting Medicaid coverage for these children to assistance for those medical conditions which made the child hard to place. In allowing this option, the Committee recognizes the fiscal pressures states are facing. However, the Committee also recognizes that for many children for whom this extension of Medicaid is directed (children with cerebral palsy and others with multiple handicaps, for example) it is extremely difficult to determine which of a child's medical needs are related to a particular handicapping condition, and in such instances full coverage is probably essential to ensuring these children permanent adoptive families.

The Committee also allows the State to determine whether to provide coverage for these children only until they find the need for the continuing medical care and services no longer exists, or up to the age of eligibility for children under the State plan. The Committee believes the certainty of the time of coverage of the second option, and the greater ease of administering it, justifies providing this option to the States.

As with other children covered under the program, a State may extend this coverage to children under 18, to children under 21, or to children under 18 and reasonable classifications of children between 18 and 21. It is expected that the standard used would be uniform for

all children covered under the program, i.e., if the age 18 cut-off is used generally in the program, it would also be used for the children placed for adoption.

Residency Issues

The reported bill gives the Secretary specific authority to establish standards for determining whether a person lives in a State for purposes of Medicaid coverage. The Committee has long been concerned with the problem of persons in nursing homes and other institutions who are unable to secure Medicaid coverage because they may have lived in one State before entering an institution which is in another State. This frequently occurs in locations close to State borders, particularly if there is a shortage of available beds in nursing homes in the original State. The Committee's concern on that score was increased during considerations of the CHAP legislation because of indications that migrant children would be unlikely to secure Medicaid coverage unless the issue was resolved. Accordingly, the reported bill replaces the requirement of residency in a State with a determination that the individual lives in the State, and provides specific authority to the Secretary to establish standards through regulations so that disputes can be resolved.

The Committee wishes to assure program participation by children of migrant families which statisfy the income and resources criteria of eligibility. More fundamentally, however, the Committee wishes to assure Medicaid coverage for any individual or family entering a State with an intention to remain indefinitely or for a permanent period. The Committee understands that the statute currently prohibits a State from imposing any requirement which excludes an individual who resides in a State. The Committee has learned, however, that in the past, States have interpreted this provision to require that a family be domiciled in a State in order to be eligible for medical assistance. The Comimttee understands that "residence" refers to a family's or individual's physical presence or abode while "domicile" refers to a family's principal or legal home. Construction of the "residence" provision as a "domicile" requirement has resulted in a denial of eligibility to families, children, and individuals residing outside their home-base state.

The amendment clarifies the Commitee's intent to extend Medicaid eligibility to all individuals, families, and children who are categorically and financially eligible for the program, whether as a result of the new CHAP eligibility requirements or otherwise. The Committee is aware that regulations recently promulgated by the Secretary (44 Fed. Reg. 41434 and 41459, July 17, 1979) clarify the procedures for determining the state of residency for institutionalized persons and also provide a new residency test for families travelling the migrant stream. However, without the residency amendment of this bill, the Secretary is without authority to establish a broad-based residency test for all families and children.

By creating a new statutory residency provision for the Medicaid program, the Committee's bill authorizes the Secretary to establish a residency test for all families and children who live in a State. While the Secretary's recent regulations provide some relief, they do not

create such a broad standard for all potential recipients, and therefore. the Committee expects that they will be revised accordingly. The Committee anticipates that the new regulations will require States to extend Medicaid coverage to all eligible persons living within their borders. The Committee is most concerned that Medicaid be provided as quickly as possible to all qualifying families and children, whether migrants, institutionalized, AFDC foster care, or CHAP mothers and children. The Secretary may of course establish procedures which will permit States which furnish medical assistance to recover from the actual State of residency if a final determination reveals residency status outside the State furnishing medical assistance. Further, it should be noted that it is not the Committee's intent to extend eligibility to individuals who merely are passing through the State or vacationing in the State.

The changes relating to residency contained in the Committee bill do not affect a basic requirement of the Medicaid program: that assistance is available only for United States citizens or aliens lawfully admitted for permanent residence. While this requirement is currently incorporated into the Medicaid program by regulation (paralleling the requirements of the law for SSI recipients), the Committee bill makes such a condition a part of the Medicaid statute. It should be noted that any citizen or lawfully admitted alien who meets the other eligibility requirements of the law would be entitled to medical assistance; any person who was not a citizen or an alien legally admitted for permanent residence would not be entitled to coverage, even if other eligibility conditions were met.

ELIGIBILITY FOR PREGNANT WOMEN

The reported bill provides for Medicaid eligibility for needy women during the course of pregnancy and except for certain circumstances discussed below, for 60 days following the pregnancy for both the mother and the child resulting from the pregnancy. It also establishes a national maternal income standard for determining eligibility of these women.

The Committee was concerned that Medicaid eligibility is denied to pregnant women in many States unless they already have a dependent child. The result is often inadequate medical care or no prenatal care at all during the course of the pregnancy. The Committee's proposal to cover all needy children under 18 will result in Medicaid eligibility for some teenage first-time mothers. To assure that coverage is available to all poor women, however, during and immediately after pregnancy, the Committee felt a specific provision giving eligibility to pregnant women was necessary.

For purposes of determining eligibility the Committee intends that "pregnancy" begin on the date of approximate conception, according to medical verification. Further, determination of pregnancy is intended to make the woman eligible to have payment made on her behalf for the diagnostic services that were necessary to determine that she is pregnant. Once eligibility has been determined, the woman becomes eligible for all services included in the State Medicaid plan. This provision assures that Federal matching for those services would not

be denied because the pregnant woman did not qualify as an AFDC-mother; her specific eligibility would be clear. It should be noted, however, that Federal matching or medical services to the mother would be subject to any general limitations of the law. The 60 day eligibility period following termination of pregnancy applies to any child born as a result of the pregnancy and to the woman, whether or not her pregnancy ended in live birth, with one exception. If pregnancy termination is the result of abortion, (unless the abortion is as a result of rape, incest, or a condition threatening the life of the mother) the 60 days of eligibility following termination of pregnancy provided to women who are not otherwise eligible for Medicaid will not be granted.

Just as the Committee believed the value of care for children argued for establishing a minimum nationwide standard for eligibility, the desirability of assuring prenatal care to the very poor was seen as a persuasive argument to establish a minimum national maternal income standard. Because of the special health needs of a woman during pregnancy, that standard was established at 80 percent of the official poverty level, adjusted according to the family size of the family (if any) of which the woman is a member. In 1980, this would mean an eligibility level of about $2,960 for a single woman having her first child. As with the nationwide standard of income for children, this level is a minimum. A State could have a higher income standard in its Medicaid program under which the woman could qualify.

In determining the income of the family of which the pregnant woman is a member, the Committee expects that only income (and resources) which are actually available to the women will be considered. Thus, only the income of the other persons in the economic unit of which she is a member will be included. If, for instance, she is not living with her parents, their income should not be counted. Also, as with the nationwide standard for children, allowable resources would be those used by the State in its AFDC or Medicaid program, and disregards of income would parallel the disregards used in determining eligibility for AFDC.

It should be noted that a pregnant woman might be eligible as part of a number of different coverage groups simultaneously: as an individual under 21, as a member of an AFDC family, and as a pregnant woman. The intention of the Committee is that she be covered under the classification that provides her with the most comprehensive coverage.

The Committee is aware that in some states the delay in getting qualified newborns certified for Medicaid means that low income families do not have coverage to pay for complications which require medical care immediately following delivery.

To address this problem, the Committee's bill provides Medicaid coverage immediately upon birth to any child (or children in the case of multiple births) born to a Medicaid-eligible woman, even if the woman has not applied for Medicaid for that child. Under the Committee's bill, newborns will be considered certified for Medicaid from the moment of birth and for 60 days following such date. The child (or children) will be CHAP-eligible children with the same protection from copayments and from limits on amount, duration, and scope

as are afforded all CHAP children. The Committee expects States to make the necessary arrangements for certifying newborns for Medicaid to assure that all eligible infants are on the Medicaid rolls once the 60 day period of automatic eligibility ends.

The Congressional Budget Office has estimated that 220,000 poor pregnant women will gain Medicaid eligibility for prenatal and postnatal care as a result of the provisions of the Committee's bill.

SERVICES

The reported bill contains provisions expanding required services under the Medicaid program by requiring comprehensive health assessments for all children, as well as immunizations, routine dental care, treatment of vision and hearing problems (including eyeglasses and hearing aids), ambulatory mental health services, and other ambulatory services; by overriding any amount, duration or scope limitations States may have placed on basic Medicaid services (such as hospital and physicians' services) for children; and by clarifying that prenatal and postnatal services must be covered in all Medicaid plans.

Comprehensive Health Asessments

The Committee intends the Child Health Assurance Program to move beyond a screening model where the emphasis is on conditions that can be found by a single, rapid test or procedure, in settings with large numbers of children. The intent is to introduce children to an ongoing source of primary care where they receive comprehensive health assessments (at regular intervals to be determined by their age) and subsequent care. The assessment should be individualized to the greatest extent possible. Parents of young children, in particular, should be involved in providing relevant health history and in receiving thorough counseling about the child's development and health needs.

Standards for the frequency and content of health assessments would be established by the Department. At a minimum, assessments should include the full array of assessment procedures set out in the current EPSDT regulations, including direct referral for dental care, plus counseling and appropriate developmental assessments. Generally, the Committee believes growth and development should be evaluated through a thorough health history, physical examination and such observation of the child as is possible in the course of performing routine procedures. Such an approach should be sufficient to uncover common problems which impair development. In establishing standards for the periodicity of assessment, the Committee expects the Department to be guided by the American Academy of Pediatrics' "Master Schedule for Screening". A public comment period on proposed standards should be allowed to provide ample opportunity for professional and consumer representatives to recommend any changes which are warranted to revise standards in accordance with recent medical advances.

While the Committee recognizes the importance of timely assessments and appropriate treatment for infants and young children, the

Committee is equally concerned that appropriate attention is placed on reaching the particular health problems of adolescents, who also need regular comprehensive medical care. This includes nutrition information, dental examination, vision and hearing testing, up-to-date immunization, and health education. Statistics on adolescent suicide, alcohol and drug use, pregnancy, venereal disease, and mental and emotional problems reveal that for many adolescents, health care and health come too late.

Services for Eligible Children

The Committee intends to assure that a service problem with the current EPSDT program is corrected. Often-times, Medicaid does not cover the treatment that children are found to need at the time of screening because of limitations in covered services imposed under the State plan. The EPSDT program currently overrides State plan coverage of assessed children only for vision, hearing and dental services.

The Committee intends that CHAP will override State plan coverage for all Medicaid children, regardless of assessment, for all those services mandated by the bill. These mandated services include all current mandatory benefits plus uniform assessments; immunizations; clinic services; diagnosis and treatment of hearing and vision problems, including hearing aides and eyeglasses; prescribed drugs, insulin; prosthetic devices; home health services; physical therapy and rehabilitative services; routine dental care and orthodontics for physical or psychological impairment; ambulatory mental health services and emergency crisis intervention inpatient mental health services.

State imposed limits on amount, duration and scope of these mandatory services will not apply, and the Committee expects that unnecessary procedures will be controlled through States' utilization control practices.

Several points should be made about the package of services required for children in the Committee bill. First, the emphasis is clearly on ambulatory services although inpatient hospital services are required, as are emergency crisis intervention inpatient mental health services.

The Committee has included this latter coverage because crisis intervention in an inpatient facility is essential for some children when they require acute, intensive intervention for treatment of an illness which cannot be effectively rendered in an outpatient or other less restrictive setting, and many communities do not have general hospital psychiatric inpatient services for children and adolescents. The Committee intends that crisis intervention be interpreted to mean not merely symptom arrest. Emergency crisis intervention should include an assessment of the child, arrest of the crisis symptoms and treatment for such symptoms.

Second, many of the services required to be offered for children are the same services which States may include at their option for the entire Medicaid population. Listing them separately is not intended to denote a difference in the service itself, but rather to signify which of those optional services are viewed by the Committee as being necessary to provide comprehensive health care to children. Further, the Committee notes that lack of specification of certain services, such as podiatry services or optometry services, are not intended to reflect a

determination by the Committee that such services should not be provided. Certain foot problems of children may clearly require treatment; if so, the Committee notes the appropriateness of their provision by podiatrists. Similarly, optometrists are a major provider of eyeglasses, and may well provide them in a cost effective manner. The Committee expects that referrals for such vision care will be made without prejudice to any class of health care provider. Of course, the recipient should continue to have the right to freedom of choice among licensed providers who are willing and qualified to offer services provided under the State plan.

Third, clinic services have been mandated as part of CHAP. The Committee intends that the definition of clinic services include at a minimum any organized entity which is primarily engaged in providing out-patient health or medical services. Some of the entities which become classified as clinic providers under the definition may be able to provide the full array of CHAP services included under the provisions of this bill for CHAP-eligible children. Others may provide only certain kinds of diagnosis or treatment mandated by CHAP. It should be noted that to be a clinic provider under CHAP does not require that the provider offer all CHAP services for which the child is eligible. However, to qualify as a CHAP provider, any entity must meet the requirements of Sec. 1913(b)(2).

Fourth, the reported bill makes routine dental care a required Medicaid service.

The record of the hearings before the Committee is replete with information, much of it from studies conducted by the Department of HEW and other government agencies, documenting the fact that undiagnosed and untreated dental disease is one of the most serious and widespread health problems affecting poor children. Also beyond dispute is the convincing evidence presented to the Committee that preventive dental health programs are extremely cost-effective both in the short and long-term. Bringing a generation of children to adulthood with good dental health is far less expensive and far more effective than attempting to treat, restore and replace teeth that have been neglected during the formative years of childhood. The need is particularly acute among children from low income families where studies have shown, for example, that such children have five times as many untreated decayed teeth as children from average income families; that only 40 percent of these children have ever visited a dentist and that 97 percent were found to require some dental care by the age of six.

The Committee also was impressed with the evidence, much of it obvious, that children with seriously diseased mouths do not perform well in school or in work; that oral disfigurements are handicapping to youths seeking employment; that thousands of man hours of work per year are lost because of oral disease; and that, most importantly, many of these unfortunate consequences of neglect are readily preventable.

The Committee has included measures in the bill to help assure that Medicaid children actually receive the dental care to which they are entitled under CHAP. In addition to covering dental care for eligible children irrespective of whether they have been assessed, the bill

seeks to guarantee that during the health assessment itself all needy children will be provided routine dental care or referred for it and followed up as necessary. It is thus the intention of the Committee that any providers of health assessments, whether or not operating under a written agreement, provide for such dental care directly or through referral. To assist providers, the state agency will provide them lists of dentists practicing in the area who agree to offer dental care to Medicaid children. The Committee expects that referrals for dental care will be followed up as with referrals for medical diagnosis and treatment.

Services for Pregnant Women

The reported bill provides a new category of services during the course of pregnancy and 60 days thereafter for any woman eligible for Medicaid coverage (who, if under 18 years of age, may also be eligible for CHAP services described in Sec. 1905(a)(4)(B) of the Act, as amended by the bill), regardless of the category through which she became Medicaid-eligible.

The Committee is concerned that in many instances appropriate prenatal and postnatal services are not available for pregnant women. Some state Medicaid plans, for example, fail to include certain services, such as clinic services, which improve pregnant recipients' access to prenatal and postnatal care. Other states restrict the availability of covered items and services by placing limitations on the extent to which services are available under their Medicaid plan. Such restrictions are often arbitrary and inconsistent with the objectives of the Medicaid program, namely the provision of covered services in sufficient amount, duration, and scope to achieve the purpose of their inclusion in state Medicaid plans. These restrictions are a special hardship on pregnant women for whom an extensive and broad range of services are medically advised. For example, some states place a 3 visit per month limitation on physician services. Such a limitation frustrates generally accepted medical and obstetrical regimes which require more frequent physician visits during the last trimester of pregnancy.

Moreover, many states place limitations on certain services, which, while otherwise permissible under federal law, are inappropriate in the case of pregnant women. Prior authorization for outpatient services and cost sharing requirements on items and services such as prescription drugs are examples of such inappropriate restrictions.

In light of these concerns, the reported bill creates a new category of mandatory prenatal and postnatal services for pregnant women. At a minimum, the Committee intends these services to include the services which are mandated for AFDC Medicaid recipients and in addition, prescription drugs and clinic services, regardless of whether these services are otherwise covered in the state plan. The Committee thereby intends to make prescription drugs and clinic services mandatory services for pregnant women.

While the Committee has not specifically prohibited limitations on the amount, duration, and scope of prenatal and postnatal services as it has done for CHAP services, all prenatal and postnatal services must be provided in sufficient amount, duration, and scope to reason-

ably achieve their purpose. The determination of sufficiency is to be based on accepted medical and obstetrical treatment and regimens and protocols.

Every pregnant patient should have available to her a well-designed medical evaluation and management program for obstetrical care.

As soon as practical in the pregnancy, the provider of care should obtain a comprehensive medical history with particular attention to criteria which may lead to determinations of high risk pregnancies.

An appropriate physical examination should be performed, preferably in the first trimester.

A plan for care throughout the pregnancy should be formulated and discussed with all patients. If a risk factor is identified for the patient, appropriate counseling, planning and/or consultations should be initiated. It is important to recognize that Medicaid eligible populations of low-income and/or adolescent women are particularly at risk of complications during pregnancy which may require additional attention and services.

The frequency of visits should be determined by the patient's individual needs. According to the American College of Obstetricians and Gynecologists, a woman with an uncomplicated pregnancy should be seen at least every four weeks for the first twenty-eight weeks of gestation, then every two weeks until the thirty-sixth week, and weekly thereafter until delivery is accomplished. Patients with active medical problems of necessity are to be seen more frequently. The interval of their visits should be determined by the nature and severity of the problem.

The Committee expects the Department to seek advice from expert professionals and to establish a minimum package of prenatal and postnatal benefits which could not be further limited by States and which would not be subject to copayment requirements.

While the Committee has not set minimum reimbursement levels for prenatal and postnatal services, it would expect the Secretary to monitor closely to assure that rates are sufficient to make provision of the benefits a reality. The Committee would encourage States to utilize inclusive rates to providers for the period of pregnancy, the delivery and postpartum care.

Co-payments for children and pregnant women

The reported bill amends the current law to prohibit states from imposing costsharing requirements on CHAP-eligible children and pregnant women (regardless of the category through which they obtained Medicaid eligibility) for any mandatory Medicaid, service, including the services made mandatory by this legislation. The Committee believes this is appropriate since preventive services for the poor should not be subject to any barriers which might deter their use by the target population.

CHAP Providers

PROVIDER RESPONSIBILITIES

The reported Bill contains a provision setting forth the requirements of providers serving in the Child Health Assurance Program: To do assessments, to provide services or refer for necessary services, and to do follow-up.

The Committee intends that CHAP introduce children to a source of comprehensive and continuing primary care services. Ideally CHAP providers will perform out-reach in the community and provide health assesments, follow-up and routine subsequent care.

The Committee intends that all CHAP providers offer a minimum range of CHAP services, including at least a provision of comprehensive assessments and the arrangement of follow-up in subsequent care. In general, it is not desirable to support providers perform strictly an arranging "function" and provide no out-reach or health services.

However, because many communities currently lack an ample supply of such providers, and because in some communities Health Departments have done an outstanding job in the EPSDT program, the Committee felt it would be unrealistic and unwise at this point to require that providers qualify as CHAP providers only if they can provide all services. The reported bill therefore allows that CHAP providers have arrangements with other entities for performing these functions, instead of actually providing all care subsequent to an assessment. For instance, a Head Start Program could arrange with a Children and Youth Project to provide treatment services it does not offer. The Committee expects states to guarantee that the arrangements agreed to are in fact happening, and to review provider performance on a regular basis, taking measures to de-certify those which do not meet the terms of agreements.

It should be noted that schools are listed as eligible providers under the program. The Committee believes that schools have distinct advantages in terms of access to children, and should not be overlooked as out-reach and assessment sites. School programs should be designed in such a way that Medicaid eligible children are not singled out, however. Arrangements for reimbursement of the school by Medicaid should be based on the determination of the eligibility of children through a review of school records. Also, there should be adequate follow-up to assure that children assessed by the school who are eligible for the Medicaid program receive their Medicaid cards entitling them to the additional services not rendered directly by the school. Since schools are unable to provide or refer for care evenings, weekends, holidays or vacation time or to have records available at these times, the school to be eligible as a provider must assure that necessary additional required services are received through contract, if necessary, with other providers.

The reported Bill contains a provision assuring that schools and other providers which normally give free care are to be eligible for reimbusement under the CHAP program.

The Committee Bill defines three types of relationships that the state agency will develop with health care providers. First, services may be performed by a physician or other health care provider who enters on a prospective basis into a written agreement with the state that requires he provide services in accordance with standards established by the Secretary and as outlined in the Bill. These services will include timely and appropriate child health assessments, provision of or referral for basic diagnostic and treatment services, necessary follow-up services, referral for or provision of routine dental care, referral for any necessary corrective treatment disclosed by assessments that the provider cannot deliver, management of the medical care of each in-

dividual assessed, and reasonable accessibility on an on-going basis. Providers are required to make such such reports to the state agency as the agency determines to be necessary to assure compliance with the requirements of the agreement.

If unable to provide basic diagnostic or treatment services or routine dental care, the written agreement may permit referral for these services. As defined in this bill, agreements require that providers insure the timely and appropriate provision of services when referrals are made, and assure the timely and appropriate provision of treatment for which referrals have been made. Exceptions to these portions of the written agreements have been made for the physician who enters into such agreement. The Committee recognizes the unique position of the physician practicing in his private office who will on occasion lack the resources to comply with this portion of the written agreement. In such cases, the physician may still enter into a written agreement but leave these obligations with the state. The state may in turn perform these services directly or contract with another provider for these aspects of the child's care.

In general, providers as defined by the Bill, need not assume all of these functions but must make agreements with other providers to assure the State that all provisions of the written agreement are met. The provider would then assume responsibility for those who are eligible and request care or are referred by outreach services.

Second, services may be provided by a physician who does not enter into prospective written agreement as defined above, but who certifies retrospectively on a claim form (a) that the assessment was provided in accordance with CHAP requirements; and (b) that reasonable provisions have been made to meet the other CHAP requirements. Since it is likely that certain of the other requirements (e.g. provision of or referral for treatment) will not have been provided by the time the physician would submit the claim, the physician's statement should connote that such reasonable provisions have or will be made as appropriate.

The purpose of allowing physicians to provide CHAP services without operating under prospective written agreements is to avoid obligating them to deliver services or achieve outcomes which they might not be able to guarantee. Given the purpose, use of the option is expected to be limited primarily to solo practitioners or small group practices whose participation in CHAP might not be feasible without this option. It is expected that states will encourage, through provider outreach efforts and through appropriate incentives, physicians to opt to become CHAP providers operating under written agreements.

Third, services may be provided by a continuing care provider. A continuing care provider is a health care provider who enters into an agreement with the state agency to provide continuing care services to a specific individual on a continuing basis. These services include: timely and appropriate health assessment; provision of basic diagnostic and treatment services; routine dental care or referral to a dentist; referral for corrective treatment not available from the provider; management of medical care of the individual assessed and assurance that the assessments are performed on a timely and periodic basis; and reasonable accessibility on an on-going basis. What distinguishes the

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continuing care provider is his agreement to take health care responsibility for a specific child, and his direct provision of basic diagnostic services and primary and preventive care. The Secretary would be expected to establish some minimum requirements for direct provision of services by continuing care providers; they should not simply be referral centers.

In establishing a category or providers called continuing care providers, the Committee seeks to encourage the participation of providers, who through their willingness to see a child on an on-going basis and through the broad scope of services offered, can provide a "medical home" for the child. It should be noted that the use of continuing care providers means that one provider alone determines whether a child receives the full benefits of CHAP. Because of the pronounced influence of continuing care providers, it is essential they offer services of the highest quality. Therefore, the Department must implement quality assurance measures which address the following kinds of standards: scope of services offered; hours when available for services; ratio of personnel to patients; availability of support staff beyond medical personnel and referral relationships with specialists.

The development of these three modes of provider agreements will allow for the maximum participation of health care providers in the program, a goal which the Committee believes is desirable.

REIMBURSEMENT; HMO'S

It is the Committee's intent that reimbursement levels to allow all categories of providers will be sufficiently high to encourage participation in the program.

This bill provides the Secretary of HEW with authority to establish the payment levels and methods for continuing care services. The Committee believes that this general authority is appropriate because of the variety of payment methods which can be employed under differing provider arrangements. The purpose of this provision is to compensate continuing care providers for the additional responsibilities and costs they bear in providing medical case management and ongoing primary care services to children under continuing care arrangements. The Committee intends this provision to serve as an incentive to providers to offer continuing care services.

The following are alternative policies which the Secretary may employ:

(1) A medical case management fee or retainer paid annually or semiannually for the continuing care provider's efforts.

(2) Alternative to or in conjunction with a case management fee, a minimum schedule (or regional/statewide schedules) of fees for pediatric services at or above which States would have to pay for the services of continuing care providers.

(3) Prospective, all inclusive payments or capitation rates which cover a variety of service packages differing in scope depending on the capacity of a particular provider to provide a more or less comprehensive package of services. For example a physician, a community health center and an HMO might all receive capitation payments for different arrays of services and thus should be paid varying amounts.

The Committee recognizes that certain payment options need first be developed in demonstration settings before adoption generally throughout the program. Prospective or capitation payment mechanisms for providers other than full-fledged HMOs or community health centers require testing in a demonstration setting.

In the case of HMO's the committee bill requires the State to enter into arrangement with them in order that individuals who are eligible for services under this program who choose to have their health care delivered in the HMO setting may do so. The committee included two features in the bill to provide incentives for the HMO to enroll eligible persons and provide continuing care. The first permits the Secretary to allow payments based on a prospectively determined capitation rate paid on a periodic basis. This provision will enable a CHAP beneficiary to enroll in an HMO and have the member dues paid on the same basis as all other HMO members. It will eliminate the costly and administratively burdensome claim forms to obtain payment from the State. The Secretary may develop procedures by which reports on the health care provided under the program in an HMO may be derived by an audit by the HMO of a representative sample of medical records.

The second incentive for the HMO to enroll persons eligible for the program is a requirement that the State pay the HMO at a rate determined by the Secretary to be not less than 95 percent of the average expenditure by the State for medical assistance for individuals under the age of 21 in the State. The committee believes that where States are not now paying a sufficient amount to provide the preventive and well child care services or where the benefit packages are minimal, that this payment would also be an incentive for persons eligible under the program to select the HMO and additionally increase State savings.

The Secretary may develop procedures whereby if an HMO determines that the payment at 95 percent exceeds the reveneus required to provide all health care services within the capacity of the HMO, it may choose to accept a lesser sum from the State or agree to provide additional services or cover other eligible members of the family. Any sums actually rebated, of course, would be expected to be shared with the Federal government according to the proportion of costs the Federal government originally paid.

The Committee believes that effective quality controls must accompany such innovative reimbursement schemes. Particularly with preventive and primary care, for instance, prepayment can result in underservice to the client population. The Department should develop appropriate monitoring to insure that children receive the intended benefits from continuing care providers.

While the Committee intends to encourage the participation of qualified HMO's in the CHAP program, it recognizes the potential for abuse by HMO's not equipped to or not willing to fulfill the complete requirements of CHAP. As is generally true under the Medicaid program, only those HMO's which meet the federal requirements under the HMO Act will be considered qualified to participate in the CHAP program on a nat-risk basis under the reimbursement terms set out in Sec. 1913(d). It remains possible for other pre-paid health providers to be certified for and reimbursed for providing CHAP services through other Medicaid provisions.

STATE PLANS FOR CHAP

The reported bill requires States to develop and make available for public comment their plan for implementation of a child health assurance program.

The Committee recognizes that unlike other Medicaid services, CHAP's mandate includes assuring that children actually receive an array of health services. Therefore the Committee has established a different planning mechanism than that used for other parts of Medicaid. States will be expected to develop and continually revise a program plan for CHAP which demonstrates how the major requirements of the program will be met. In meeting the State plan requirements set out in the legislation, implementation plans should describe:

how recipients will be effectively informed about the benefits of the program

how mandated support services will be arranged for or provided

how assessments and subsequent care will be provided promptly

how qualified providers will be identified and encouraged to participate in the program

how the terms of provider agreements will be monitored

how coordination will be accomplished with other programs providing health care services to children.

The Committee believes that fostering involvement from a range of qualified primary care providers is one of the highest priorities for the CHAP program. It is clear that in order for the needs of CHAP children to be cared for properly, all qualified health resources must be usilized in the program. A recipient's right to "freedom of choice" among providers is an additional reason why we expect states to make vigorous efforts to elicit the participation of the range of providers in each community who are qualified to fulfill the responsibilities as set for in the legislation.

The Committee heard extensive testimony on practices in states which currently exclude a host of qualified providers from being reimbursed for EPSDT services. It is the Committee's belief that States must move beyond an exclusive reliance on public health agencies, or private physicians to use resources including but not limited to qualified Headstart and day care programs, primary care clinics, community centers providing a range of family services, rural health clinics, solo physicians, and projects funded by the Bureau of Community Health Services, DHEW, among others.

Therefore, the bill requires state CHAP plans to identify and make provision for agreements with all qualified health care providers. The bill also provides that such providers should include any of a series of persons or entities listed in Sec. 1913(b)(3) qualified to meet the CHAP provider responsibilities. The Committee intends that states encourage participation by all qualified providers.

Further, in view of the particular problems of finding adequate numbers of dental providers in many States, the Committee emphasizes that States may include in their CHAP programs professionally sponsored, non-profit dental service corporations which have agreements with providers to render dental services.

To effectuate the widest possible provider participation, we expect the states to work with provider organizations to educate them about the program, to determine the most effective way of identifying all qualified providers, and to establish contractual terms capable of eliciting broad provider participation. Contractual terms should include: reimbursement levels which reasonably cover the cost or are competitive with prevailing rates for all services provided (including reporting as well as outreach and follow up services if given by the provider); reasonable reporting arrangements; and prompt payment of claims.

One further point should be made. In seeking out all eligible providers for CHAP, the Committee would urge that the single State Medicaid agency make use of other departments of State and local government which can contribute to a successful effort to find and serve poor children. For example, when the school health program is administered by educational jurisdictions, the single state agency would be expected to enter into agreements with local education agencies through the State Education Agency, if that would result in more children being reached more effectively.

Because the Committee recognizes how crucial it is to provide children with CHAP services, it has included a provision requiring state agences to assure that providers comply with terms of provider agreements or provider certification of services. The Committee is well aware of the unique expertise providers have in conducting their practices in the best interests of children. Yet we also are aware of the incomplete care provided to Medicaid recipients in the case, for example, of certain pre-paid health programs and solo physicians. We believe the license to practice freely and flexibly can be balanced with the need to assure that children are receiving high quality CHAP services.

The Committee bill therefore includes a requirement that states assure the compliance of providers with provider agreements or certifications, including continuing care providers and a representative sample of providers using retrospective certification. We expect that providers who are not substantially adhering to the terms of the agreement will not continue to be used as CHAP providers, and that the state will take reasonable steps to identify other providers with the capacity to care for children losing their services.

The Committee believes that the nonmedical services in CHAP are as central to the program's effectiveness as the medical services. Throughout the hearings, the Committee heard testimony about the barriers that stand between families and providers of care: lack of information about services, inability to find a provider, and lack of transportation.

It is the Committee's intent that the State plan clearly address how families will be informed of the program, what arrangements will be made to assist them in finding and getting an appointment with a qualified provider, how follow-up will be assured, and how necessary transportation will be arranged.

The Committee bill contains requirements that States allocate a reasonable portion of program funds for outreach to poor children and low-income pregnant women, and for follow-up to assure that they receive necessary services. The Committee notes the follow-up activi-

ties may encompass some basic health education to assure that proper health habits are followed and necessary treatments taken.

INCREASED FEDERAL SUPPORT FOR HEALTH CARE FOR CHILDREN

Increased matching rate for services

The reported bill establishes two increased Federal matching rates. One rate applies to the costs of health assessments and all non-inpatient services provided to children who have been assessed and reassessed at appropriate intervals as determined by the Secretary. This rate is determined by adding 25 percent points to the existing Federal medical assistance percentage, up to a maximum of 90 percent. The second increased rate, the continuing care matching rate, applies to all non-inpatient services provided to children who are under the care of a continuing care provider. This matching rate is determined by adding 30 percent points to the existing Federal medical assistance percentage, up to a maximum of 95 percent.

The Committee was concerned that some States had been slow to implement the EPSDT program due to a fear that, whatever its long-run savings, the program could result in a short-run increase in costs. This concern was believed to be a contributing factor to the woefully inadequate outreach and screening efforts that have characterized some State programs. The Committee believes that there can be no better investment of Federal funds than in improved health care for children. Further, by making the increased matching rates available only for non-inpatient services, it hopes to encourage the use of ambulatory care wherever possible. That the Committee recognizes the continued importance of assessments is evidenced by the higher matching rate for assessed children. However, the Committee feels strongly that assessment is not enough. There is an additional need to encourage greater continuity of care for Medicaid-eligible children. The Committee feels it is time to move away from the fragmented nature of service delivery to Medicaid children. The importance of preventive care, recognized in the higher matching rate for assessed children, must be combined with a recognition of the importance of continuing care, of guaranteeing a "medical home" for Medicaid children, a regular source of care for both preventive and treatment services, is recognized by the Committee in both the higher matching rate for continuing care and the added weight given to continuing care in measuring state performance.

The Committee notes that appropriate adjustments will need to be made to determine the appropriate Federal share for costs of assessments and ambulatory services provided in an HMO setting. The Committee would expect the Secretary to develop procedures for estimating the relative portion of the per child payment being made to an HMO which covers ambulatory and assessment services, and allow the higher Federal match on that amount.

In filing the financial reports on which the higher CHAP matching rates are claimed, the Committee expects that States will have collected documentation supporting the number of children and the amounts claimed at each of the higher matching rates. States would be required to make such documentation available to the Federal Government for monitoring purposes. The Secretary shall determine

the appropriateness of the amounts claimed under CHAP matching rates by periodically sampling a State's documentation. Since States are entitled to two different higher matching rates, a separate sampling effort will be required for each rate. If such a sample indicates that the amount of Federal monies claimed by a State was in error, the Secretary will make a proportionate disallowance on the aggregate amount of funds claimed at the higher matching rate. If subsequently a State can document to the satisfaction of the Secretary 100% of the initial claim for federal matching (including any necessary proof of assessment from earlier periods), and a lesser error rate and disallowance is indicated, the Secretary shall adjust the disallowance accordingly. If a lack of documentation prevents the Secretary from performing the initial review to validate expenditures at the higher matching rate, then the higher matching rate will not be available to the State.

The following table shows both of the CHAP matching rates:

CURRENT MEDICAID FEDERAL MATCHING RATES AND RATES UNDER CHAP, BY STATE

[Federal percentage]

State	Current matching rate	CHAP matching rate for ambulatory services for—	
		Assessed children	Continuing care children
Alabama	71	90	95
Alaska	50	75	80
Arkansas	73	90	95
California	50	75	80
Colorado	53	78	83
Connecticut	50	75	80
Delaware	50	75	80
District of Columbia	50	75	80
Florida	59	84	89
Georgia	67	90	95
Hawaii	50	75	80
Idaho	66	90	95
Illinois	50	75	80
Indiana	57	82	87
Iowa	57	82	87
Kansas	54	79	84
Kentucky	68	90	95
Louisiana	69	90	95
Maine	70	90	95
Maryland	50	75	80
Massachusetts	52	77	82
Michigan	50	75	80
Minnesota	56	81	86
Mississippi	78	90	95
Missouri	60	85	90
Montana	64	89	94
Nebraska	58	83	88
Nevada	50	75	80
New Hampshire	61	86	91
New Jersey	50	75	80
New Mexico	69	90	95
New York	50	75	80
North Carolina	68	90	95
North Dakota	61	86	91
Ohio	55	80	85
Oklahoma	64	89	94
Oregon	56	81	86
Pennsylvania	55	80	85
Rhode Island	58	83	88
South Carolina	71	90	95
South Dakota	69	90	95
Tennessee	69	90	95
Texas	58	83	88
Utah	68	90	95
Vermont	68	90	95
Virginia	57	82	87
Washington	50	75	80
West Virginia	67	90	95
Wisconsin	58	83	88
Wyoming	50	75	80

Maintenance of Effort

The reported bill requires that the receipt of the increased Federal matching described above is conditioned on a State taking no action during the first 4 years after enactment to reduce the current State Medicaid coverage of children. The Commitee does not intend that the increase in Federal matching be a windfall to States which then act to reduce their current program coverage.

CHAP is intended to be an improvement and expansion of the EPSDT program. The Committee, therefore, intends that any and all entitlements to which beneficiaries currently have a right under each States' EPSDT and Medicaid program be maintained and the current eligibility for children not be reduced. The intent is that States not cut back benefits in any way. They should not reduce the categories of children covered by Medicaid, the income or resource standards used to determine eligibility, the services covered, or the amount, scope, or duration of those covered. The sole exception to this is that a State may change is coverage to limit it to those under 18 (and those receiving AFDC payments), in accordance with the changes made by this law a State would be expected, however, to protect the eligibility of current recipients between 18 and 21 by including as a reasonable classification the members of this group; that is, by "grandfathering" them into coverage.

The 4-year limitation on the maintenance of effort requirement is included because of the Committee's belief that once four years of expanded coverage at the higher match rate have passed, cut-backs are unlikely, and the consequent need for the provisions with the administrative problems it would entail is so reduced as to make it unnecessary.

Increased Federal Matching for Outreach and Follow-up Services

The reported bill contains a provision for a Federal matching rate for the costs of outreach and follow-up services of 75 percent.

Under the EPSDT program, States generally attribute outreach cost to Medicaid administrative expenditures and are reimbursed at the 50 percent federal administrative matching rate. Some States, however, have taken advantage of a special Medicaid provision which allows for reimbursement of outreach services performed by public agencies with medical supervisory personnel at a 75 percent match. Under this provision, outreach must be carried out by employees of an identifiable Medicaid or EPSDT unit at the local level and under the supervision of skilled professional, medical personnel. The higher matching rate is not available currently for outreach conducted by non-profit, community organizations. The Committee proposal would remedy that situation.

Based on testimony the Committee received and lessons from the experience of EPSDT, the Committee is convinced that effective outreach is the key to extending CHAP's benefits to eligible children. Outreach includes informing families about the service and assisting them to find a provider set up an appointment, and get to the provider.

A summary of outreach studies provided by the Department makes clear that effective outreach consists of personal contact with families by persons they know and trust who are trained to explain thoroughly

the value of the program and to assist making arrangements to get services. Yet most states now use outreach methods which are largely ineffective written notices and explanations by welfare professionals at the times families come to the welfare office for certification or recertification.

A large number of States rely on their social services agencies to implement outreach. Under this arrangement, a common method used to comply with the program's requirement to notify eligible families has been to enclose a brochure with the families AFDC check describing EPSDT. It is also typical for States to notify families at the time of certification for public assistance where the families receive written material or is told about the program.

These methods are recognized as being among the least effective ways to perform outreach services. Program administrators and recipients alike have acknowledged that written notices have had little impact. Contact with welfare intake workers during certification also has its drawbacks. Unless specifically trained, such workers often do not know enough about the program to provide an adequate explanation to parents.

A General Accounting Office (GAO) report, "Improvements Needed to Speed Implementation of Medicaid's EPSDT Program", revealed that inserts mailed to beneficiaries in the State of Washington resulted in a participation rate of only 2 percent. Once the State implemented the EPSDT Improvement Project, a one year program in which the State employed 240 people to promote the EPSDT program and perform intensive outreach services, the number of screening claims paid during the last seven months of the project amounted to an 89 percent increase over the same period in the previous year.

Washington's experience, and that of several other States, supports the premise that successful outreach does depend to a large degree on the level of resources committed to outreach and on the willingness of the State to use techniques that go beyond minimum notification requirements. The number of community organizations performing EPSDT outreach under the current law's matching provision is very small. Yet community organizations tend to use more innovative techniques such as personal contact through extended home visits which appear to be effective in locating eligible children. They are more likely to employ indigenous workers who are especially effective in reaching children with different ethnic or cultural backgrounds. This also has the spillover effect of creating employment opportunities for local residents. These organizations tend to regard outreach as active casefinding, and within this context may combine casefinding with case monitoring which helps improve the continuity of care by facilitating referral and follow-up treatment. Community organizations are likely to promote basic screening and treatment within comprehensive care settings; this is in contrast to a more fragmented program in which outreach, screening and treatment are provided by separate entities: the welfare department and/or health department and a private provider.

A graphic example of outreach being conducted by a community organization which demonstrates the effectiveness of this technique is that of Operation Life in Clark County, Nevada. Operation Life, a

non-profit community group employing AFDC beneficiaries, began to conduct EPSDT outreach in August 1973. Within 18 months, 3,120 children, or 80 percent of the eligible population had been screened. Of these screened, 80 percent received dental referrals and of these, 50 percent were seeing a dentist for the first time in their lives. The program was responsible for screening 2,510 children in 1975 and 2,614 children in 1976. In 1977, the health department assumed responsibility for performing outreach services and during that year screened 1,210 children—a significant decrease in the numbers of children reached by the program.

Outreach takes on special importance under CHAP because the proposal extends Medicaid eligibility to a group of children and pregnant women whose eligibility is not categorical and who are not members of families receiving cash assistance. These newly eligible children and pregnant women will be more difficult to locate because they do not have on-going contact with caseworkers. The Committee has mandated outreach to Medicaid-eligible children and expectant women, whether newly eligible as a result of CHAP or eligible under other sections of Medicaid law. Outreach should include identification and location of eligible individuals, informing them about the program, and such other supports (such as help with scheduling an appointment and transportation assistance) as necessary for eligible children and pregnant women to use CHAP services.

The Committee intends to encourage all kinds of effective outreach methods. To promote such arrangements, we intend to remove two requirements which in the past have governed reimbursement of "administrative support services" at a 75 percent federal match. Current policy requires that the activities be carried out by: (1) "an identifiable Medicaid or EPSDT unit at the local level" and (2) under the direct supervision of "skilled medical personnel". The Committee intends that the CHAP match of 75 percent be available to public as well as private, nonprofit organizations and that such support staff need not work under the direct supervision of skilled medical personnel.

The Committee intends that states use outreach approaches which are most efficient and effective in encouraging families to participate in CHAP. The value of employing trained paraprofessionals from the poverty community has been demonstrated and, in the interests of both cost and efficiency, their use should be encouraged. The value of having primary care centers employ such paraprofessionals to perform outreach is also clear. Particularly where such centers currently include community outreach in their range of services, we expect CHAP outreach will be performed (and reimbursed) by such organizations. Therefore, the 75% match for both outreach and follow up is available when these services are provided through a separate contract and the cost for these services should be covered by the reimbursement terms in the contract.

The Committee is aware that under EPSDT, organizations other than welfare agencies have been unable to obtain names of children on Medicaid in order to perform outreach. The Medicaid statute purports to protect the confidentiality of families' welfare status by prohibiting release of information unless its use is connected with the

administration of the program. We intend to preserve such confidentiality. However, for organizations beyond welfare agencies to be used for outreach, as we intend, they need access to names of Medicaid children. Names of children on Medicaid should be available to organizations performing CHAP outreach so long as the organization is performing CHAP outreach, under agreement with the state. Such use is connected with the administration of the program and is consistent with Medicaid policy.

It should be noted that in some cases, follow-up activities will be done directly by providers as part of their agreement with the State. In this case, payment for follow-up would be part of the reimbursement to the provider; the Committee would not expect amounts covering the costs of follow-up to be broken out or claimed separately for purposes of the 75 percent match. Those costs would be matched at the same rate as assessments and ambulatory services to an assessed child. Where follow-up is contracted for, however, and a specific rate for follow-up (or follow-up and outreach together) is determined, these costs would be administrative and matched at 75 percent.

STANDARDS FOR ACCEPTABLE AND OUTSTANDING PERFORMANCE

The Committee recognizes that the program requirements under EPSDT have failed to extend the intended benefits to eligible children. In response to this deficiency, the Committee has structured CHAP to place an emphasis on actually reaching needy children with assessments and subsequent care.

The reported bill establishes standards for minimum and reasonable performance under CHAP, criteria by which to measure performance, as well as bonuses and penalties related to the performance standards. A State's performance is measured as the ratio of children assessed and treated, children who are not due for an assessment (i.e. already up-to-date), and children under continuing care, to the number of children enrolled in Medicaid. The number of children under continuing care is weighted by a factor of 1.2. This weighting is intended to emphasize the importance of this type of care and to provide an additional incentive for States. If the ratio is below the minimum level of performance (a ratio of less than 25 percent), a State will be subject to a penalty amounting to 20 percent of the Federal share of administration and training costs. If the ratio is greater than the level of reasonable performance (a ratio of 50 percent), a State will receive a bonus, again a percentage of the Federal share of administration and training costs. The bonus percentage is related to the State's performance ratio in the following manner: for each two percentage points by which the level of State performance exceeds the level of reasonable performance, the amount of the Federal share of administrative costs will be increased by 1 percent.

The performance standard neither changes nor interferes with the voluntary nature of this program. Recipients retain the right to decline services and states are prohibited from using any form of coercion to get families to use services. We have included these standards because the experience of EPSDT shows that it is possible to establish an expected level of participation which accomodates the fact that some

eligible families will decline service. The performance standard, then, reflects the results which state effort should produce (once relevant considerations have been factored in), assuming that effective informing and other forms of assistance are provided as intended by CHAP.

The Secretary is responsible for measuring the level of state performance. The bill requires that a performance ratio or score be determined at least twice a year and assess performance over a six month period. The Secretary may measure performance during the first such six month period on the basis of services delivered during the first three months, in order to allow States to assemble the required documentation. Thereafter, the documentation would be expected to cover the full six month period.

The Secretary will determine State performance on the basis of a random, statistically valid sample of all children under the age of 18 who were enrolled in the Medicaid Program for the entire 6 month period for which performance is being assessed. A statistically valid sample of each provider type (continuing care providers, regular CHAP providers, and physicians not operating under written agreements) should be included.

For each of the children in the sample the Secretary shall determine whether or not they were under continuing care as of the last day of the six month period. This determination will require a review of the child—specific provider agreements signed by continuing care providers. For all children who are not covered by such agreements, the Secretary shall determine the most recent date at which a child became due for an assessment, and whether or not each child received that assessment.

A State is expected to assess a child in a timely manner—within 60 days of his request (if there is one), or of determination of eligibility unless the child has previously been eligible and so has an up-to-date assessment but in no case later than 4 months from the date the child would be due an assessment under the periodicity schedule.

Further, the timely and appropriate provision of follow up treatment is required. The Committee expects that timely service provision will be defined as at least within 60 days.

The Committee wants to make clear that in determining actual performance, states are credited with enrolling a child only if the child received necessary care and services covered by a written agreement or physician certification. We expect the Department will determine that the requirements set out in Sec. 1913(b)(2) have been fulfilled as a basis for counting children as enrolled in CHAP.

In determining whether or not a child has been (or is being) treated for conditions found during assessment, the Secretary need only establish that treatment has been initiated with appropriate providers, not necessarily completed. The Committee, by linking assessment and treatment in this manner, addresses the problems of follow-up care and what, in some programs, could be viewed as an underemphasis on treatment of conditions found during assessment.

The Committee intends to recognize the cumulative nature of a State's child health efforts by including in the performance ratio the number of children who were assessed (and treated) in earlier periods and are still up-to-date or, not yet due for a reassessment, according to the periodicity schedule.

While it is the responsibility of the Secretary to make performance determinations, the Committee expects that States will maintain and make available to the Secretary the appropriate documentation on the status of children enrolled in the Medicaid Program and the services those children have received. If a State fails to cooperate in providing the necessary documentation, or is unable to do so, the Secretary will assume that the State failed to reach the minimum level of performance (25 percent) and will take a penalty accordingly. Some of the necessary data will be collected from providers and the Committee anticipates that the use of a uniform claim form for ambulatory services to children will assist State data collection. It is also expected that the Seceretary will provide States lacking adequate case management or automated tracking systems with the technical assistance necessary to select and implement such systems. In order to make a performance determination the Secretary will require from the States:

documentation regarding the numbers of children enrolled during the performance period being reviewed, including birth dates
assessment, diagnosis, and treatment documentation
provider agreements
documentation on children under continuing care.

We have built in an opportunity for states to correct program deficiences and thereby avoid imposition of the financial penalty. However, the Committee intends that the correction period be used in a serious manner by states committed and able to achieve compliance within a reasonable time. To assure that the correction period not be used as a means of delay when little concrete progress is made, states requesting correction time should be expected to demonstrate to the Secretary a remedial plan capable of achieving compliance by the end of the correction period. The 6 month correction should be granted based on the Secretary's judgment that the proposed plan will accomplish satisfactory performance and that the state is capable of carrying out the proposed plan. In opting for a correction period, a state is admitting it has deficiencies to correct. After seeking a correction period, then, we believe states would generally not appeal HEW's finding of noncompliance.

A state would not be entitled to two successive six month suspensions of the penalty. For example: a state is found to have unacceptable performance during one period, and the penalty is suspended while the state attempts to improve its score. If the next regular sampling and performance determination indicates continued performance below the minimum level, then the state would not be entitled to a second six month 'grace period'. Rather, it would be penalized for its performance in the second period and penalized retroactively for its performance in the first period. If, on the other hand, a state is found to have brought its performance up to the minimum level during a six month suspension of the penalty, then no penalty would be assessed for the single low score.

In addition, a state shall not be allowed more than one opportunity per quarter to demonstrate that performance has been corrected and is acceptable. From the date that the Secretary is satisfied that the corrections have been made, there would be no further quarterly reductions (due to the earlier finding).

It should be noted that the State performance is determined by the proportion of enrolled children that are assessed and served. The Committee selected enrolled children, that is, children who have had a formal determination of Medicaid eligibility, because that number is measurable and discrete, whereas estimates of eligibles (that is, persons who could be eligible under the standards but who may or may not have applied) are variables and inexact. However, the Committee is concerned that use of enrolled children to judge performance should not result in a deterrent to States bringing as many eligible children as possible into their Medicaid program. Therefore, the Secretary is directed to study the relationship between eligibles and enrolled children, and make recommendations concerning the appropriateness of the measure selected. If the Secretary finds evidence that the ratio of enrolled population of Medicaid children in a State to the estimated number of eligibles is significantly less than generally occurs in other States, he is directed to require the State to submit a plan for more effective outreach. If he finds a satisfactory plan is not implemented, he is directed to undertake directly, or contract for, outreach services in that State. The costs of such services would be considered to be an administrative cost incurred by the State, and the State would be expected to pay its share of those costs.

UNIFORM REPORTS AND CLAIM FORMS

The Committee bill is designed to remedy a deficiency of the current EPSDT program; namely, that services shown to be necessary during the screening process are often not received. The Committee bill provides higher Federal matching for ambulatory services provided to children with up-to-date assessments. In order for this to be determined, individual case records must be maintained by the State to show the services each individual received. To determine the appropriate amount of Federal funds due, all records must be reviewed.

In order to encourage more usable information for the child's record, the bill provides for use of a uniform claim form by CHAP providers.

Most of the claim forms now in use in the various States reflect the episodic or fragmented nature of the health care services paid for by Medicaid. By and large they do not lend themselves to tracking care for a given individual over time. Even in those instances where a State has established a separate claim form for an EPSDT screen, the treatment that stems from that screen can be reported on any of several claim forms, depending on the type of provider. Since it is thus difficult to pair back or link treatment services to screens, tracking is reduced to knowledge of an isolated screen and perhaps a summary of the problems found and referrals made. This leaves both the States and the Federal government in the position of not being able to easily monitor even the short-term progress of a child through the EPSDT system. Needless to say, it also makes it extremely difficult to track, via the claim forms, the status of an individual child's health and the impact of preventive care and services. A nationwide mandated claim form for all ambulatory services to children under Medicaid can serve to both highlight the gaps in the delivery of services to children, and assist States in identifying duplicate or overlapping services.

It is the committee intent in providing authority to the Secretary to develop regulations concerning uniform reports and claim forms for providers within a reasonable classification that consideration be given for recognizing that an HMO which is providing comprehensive and continuing care under a prospectively determined capitation rate does not prepare claim forms for services provided. Procedures should be developed to take account of their unique situation. In these cases, it may be more appropriate for the HMO to audit a representative sample of its medical records for enrolled persons under the program, for example, in order to prepare reports which meet the programs reporting requirements.

The Committee believes the program reporting failures in EPSDT which have made it impossible to assess the adequacy of the program, state by state, and nationally must be corrected. HEW must institute reporting requirements for CHAP which produce data on the proportion of enrolled children who receive program benefits (assessments and treatment for problems found in assessments as well as subsequent care) and the quality of care provided.

Accordingly, the Committee expects that the uniform reports and claim forms will be designed to produce data needed for proper program management. Program data should be reported:

(1) In terms of children, not procedures (i.e., number of assessments), as is currently the case;

(2) In a way that makes it possible to determine for any given period of time and portion of assessed children needing treatment who have received such treatment on a timely basis; and

(3) In a way that makes it possible to assure that children are moving in a timely fashion through the CHAP system (from initial informing through completion of needed treatment, reassessing and linking to a source of ongoing primary care).

Data on conditions found should be reported in sufficient detail to allow states to determine the adequacy of resources in an area with reference to the specific health needs uncovered through CHAP. Data on procedures performed during an assessment should be recorded in sufficient detail to allow audits by HEW and the states regarding the thoroughness of health assessments performed.

The Committee is fully aware of the danger that reporting demands could adversely affect providers' willingness to participate in CHAP. But we believe it is possible to devise reporting requirements which allow adequate program planning and monitoring without creating excessive burdens for providers. It is customary medical practice to keep thorough patient records on problems found and services provided, by date and by child. To meet the Committee's requirements, providers would need to report to the state only selected data from these records so long as complete documentation is available locally for audit purposes. In addition, the Committee intends that states establish reimbursement levels for providers which reasonably cover the real costs of keeping adequate records and forwarding necessary information to the state on a regular basis.

Although the Committee has placed an emphasis on numerical outcomes, we fully expect the Department and states to assure that the services counted by the numbers are of high quality. We expect chil-

dren to receive thorough health assessments and that all subsequent care will be monitored to guarantee complete, competent care.

Within two years following the enactment of CHAP and annually thereafter the Department is required to report to Congress on compliance activities under EPSDT and CHAP.

The Committee is fully aware that many states will have to develop new information systems and case management systems in order to assure that children receive appropriate services and to provide the management reports proposed in CHAP. The Committee believes that reporting the proportion of eligible children who receive program benefits will be the major tool in assessing the adequacy of the program. But it is evident to the Committee that the case management and reporting is difficult due to the nature of the eligible population and nature of the delivery system. The Committee realizes that every effort must be made to assist states in developing adequate systems, to handle the complexities of large numbers of children and multiple sources of medical care.

In order to accurately report the status of eligible children, case management systems must be in place to track and record each child's status in regard to screening activities. Tracking systems are complex and difficult to administer even under ideal situations. Recommended periodicity for screening examinations varies with the age of the child; for a family with several children there are multiple periodicity schedules. The population covered by CHAP creates particular case management difficulties because they are highly mobile, often moving from one local EPSDT administrative unit to another, and in addition, they often have periods of ineligibility. Uniform statewide reporting systems are also difficult to implement because most of the information is generated at multiple local and county agencies. Complete coordination is required in order to gather all necessary data.

Developing a system that can (1) provide timely information to outreach workers which assists in assuring eligible children receive necessary health care and (2) provides accurate aggregate data to the state is a highly complex task which must have the support of HEW

The Committee intends that technical assistance will be provided for, at no cost to the states, for the purpose of developing and implementing case management and administrative support systems.

STUDIES AND DEMONSTRATIONS

The Committee is eager to see the Department take steps to coordinate and bring into conformity the various Federal programs providing health services to children. We have, therefore, called for a report (to be submitted to the Congress not later than two years after enactment on the duplication of existing programs of services to children under Titles V and XIX of the Social Security Act as well as on actions undertaken and to be undertaken to reduce duplication and integrate services under these and other Federally funded programs. Such a study should identify gaps in services as well as duplication of efforts between and among programs. It should recommend action to be taken by the Federal government to coordinate and integrate child health programs.

The Committee notes that while the Department has been allowed two years to complete this study, it is urged to give it high priority and to report before the deadline if at all possible.

The reported bill permits the Secretary to conduct demonstration projects in order to evaluate the participation of health care providers in the CHAP program and to determine methods of improving their levels of participation, especially in areas where there exists a shortage of health care providers. In targeting projects in health care shortage areas, the Committee intends the Secretary to utilize the definitions of health manpower shortage area found at Sec. 332 of the Public Health Services Act.

The bill also grants the Secretary authority to waive compliance with the requirements of the Medicaid program. The Committee is concerned, however, that this waiver authority not be used to authorize demonstration projects which have an adverse impact on CHAP-eligible children. Before a compliance waiver can be granted, therefore, the Secretary must determine first, that the proposed project will, in fact, carry out the objective of the demonstration provisions, namely, to improve provider participation in CHAP; second, that the project is consistent with the purpose of the CHAP legislation, as set forth in Sec. 2 of the bill; and third, that Departmental safeguards relating to research projects involving human subjects have been complied with.

Finally, the bill authorizes the use of ⅛ of 1 percent of title XIX funds for studies on the effect of preventive and primary care services on children assessed under CHAP, the incidence of disorders found, and the costs of identifying such disorders.

ENFORCEMENT DURING THE TRANSITION FROM EPSDT TO CHAP

Under the Committee bill, there will be a period of between one and two years when state programs are no longer audited for compliance with EPSDT penalty regulations and are not yet audited for program performance under the CHAP bonus and penalty. During this interim period, the Committee fully expects the Department to take necessary measures to assure high program quality in each state. It should monitor states' progress in moving toward satisfactory performance under the CHAP performance standards. It should also work with states to insure that the service protections for children in the EPDST program (e.g. that complete health assessments are performed, that needed diagnosis and teratment are provided in a timely fashion, and that referrals are made for needed services not covered by Medicaid) are maintained during the transition periods and under CHAP. Although the EPDST penalty requirements in Sec. 403(g) are repealed 6 months after the date of enactment of this Act, Medicaid state plan requirements related to EPSDT (including a mandated screening package with direct referral to a dentist) remain in effect until replaced by the provisions in CHAP. These state plan requirements must be monitored as any other compliance issue under the Medicaid program.

HEW ADMINISTRATION OF CHAP

The Committee heard considerable testimony on the poor track record of the Department in implementing the EPDST program. We

have been extremely concerned by the footdragging on the part of the Department in issuing regulations and in vigorously carrying out the charges of EPDST. CHAP was an HEW initiative and we look for strong leadership from the Department. The mandate is a large one, and it will require careful planning, a commitment to working with the range of provider and public interests whose participation is needed to accomplish the goals, and clear programmatic guidance on the part of HEW.

The Committee expects that CHAP will be administered be an identifiable unit in the Department. The unit should have responsibility for developing program standards and reporting requirements, setting criteria for State implementation, monitoring State performance, and providing technical assistance. It should be granted sufficient staff and authority to carry out these responsibilities.

Program Oversight

The Committee's oversight activities with respect to Medicaid coverage of children and the EPSDT program of current law have been conducted by the Subcommittee on Health and the Environment in connection with its consideration of the revision of the legislation establishing the program, and by the Subcommittee on Oversight and Investigations. Legislative hearings were held in June 1979 and the findings are discussed in this report in the sections covering the background and need for legislation, and the Committee proposal. Oversight hearings on the EPSDT program were conducted in October 1975 and a report entitled "Department of Health, Education, and Welfare's Administration of Health Programs: Shortchanging Children was issued as a Subcommittee Print in September 1976.

The Committee has not received reports from the Committee on Government Operations on this subject.

Inflation Impact Statement

The reported bill is estimated to result in an increase in total Federal and State Medicaid expenditures of less than 5 percent in each of the first five years of the program.

In estimating the inflationary impact of these expenditures, however it is important to note that the monies are used largely to provide prenatal care to pregnant women, and preventive health care and early treatment to newborns, children, and young adults. Such care represents a relatively modest current investment which can be expected to result in improved future health status for this population, fewer premature births and a resulting smaller incidence of mental retardation and birth defects, and over-all a lower level of expenditures in future years, particularly for costly hospitalization and other institutional services.

It is the conclusion of the Committee, therefore, that the immediate inflationary impact of these expenditures will be minimal, and the long run effect will be to reduce inflationary pressures in the medical care field.

Congressional Budget Office Estimates

A cost estimate was requested on H.R. 4962 when it was ordered reported from the Committee on Interstate and Foreign Commerce, and the Congressional Budget Office has provided the following information:

Congressional Budget Office,
U.S. Congress,
Washington, D.C., October 25, 1979.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives,
Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 4962, the Child Health Assurance Act of 1979.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

James Blum,
For Alice M. Rivlin,
Director.

Congressional Budget Office—Cost Estimate

October 25, 1979.

1. Bill Number: H.R. 4962.
2. Bill title: Child Health Assurance Act of 1979.
3. Bill Status: As ordered reported by the Committee on Interstate and Foreign Commerce on October 16, 1979.
4. Bill purpose: H.R. 4962 woud amend title XIX of the Social Security Act in order to make additional low-income children and pregnant women eligible for medicaid benefits. It would also revamp the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), which would be renamed the Child Health Assurance Program (CHAP).

The bill would extend medicaid eligibility to all children under age 18 who are members of families whose incomes are less than either two-third of the poverty level or the applicable state medicaid standard. Coverage of children would be mandatory, henceforth, regardless of whether their families receive cash assistance. The bill would also require medicaid coverage during pregnancy and for two months after delivery for all women whose incomes are less than either four-fifths of the poverty level or the applicable state medicaid standard. Coverage for children of certain specified medical services would be mandatory, as would coverage of all pre- and post-natal medical care for pregnant women. The bill would forbid cost-sharing requirements for children and pregnant women and would also prohibit limitations on the amount, duration, or scope of covered services for children. Under CHAP, the federal share of expenditures for assessments and

ambulatory services for most appropriately assessed and treated children would be increased by 25 percentage points, up to a maximum 90 percent. The federal share of costs for outreach and follow-up efforts would be raised from 50 to 75 percent. In addition, a system of bonuses and penalties in the form of increased and decreased federal sharing of medicaid administrative expenditures would be created. A bonus would be awarded or a penalty assessed according to the performance of a state's CHAP program, as measured against specified criteria for reasonable and minimal performance.

5. Cost estimate: This bill would increase future federal obligations through extension of an existing entitlement, and would require subsequent appropriation action to provide the necessary budget authority. The figures shown as "Required Budged Authority" represent those amounts of budget authority needed to cover the outlays estimated to result from enactment.

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984
Required budget authority	131	646	1,123	1,612	1,995
Estimated outlays:					
Current eligible children	78	351	519	677	786
Newly eligible children	23	122	248	408	551
Pregnant women	10	53	105	168	230
Eligibility extensions	2	19	23	26	29
Mental benefits	2	9	11	13	15
Adopted children	(1)	(1)	(1)	(1)	(1)
Institutionalized children	3	14	15	17	18
Residency	2	10	11	12	13
Studies	(1)	3	3	3	3
Administration	11	45	92	129	152
Bonuses	0	11	96	159	198
Total estimated outlays	131	646	1,123	1,612	1,995

[1] Estimated amount is less than $500,000.

The costs of this bill fall within budget function 550.

6. Basis of estimate: This estimate assumes an enactment date of December 31, 1979. Most provisions of H.R. 4962 would become effective on July 1, 1980. The bill would require that implementing regulations be written within six months of enactment. Since the effective date is assumed to follow enactment by six months, implementation is not assumed to be delayed beyond the effective date. For provisions effective upon enactment, six months are assumed to be required for promulgation of regulations, with implementation assumed on July 1, 1980. Costs shown for fiscal year 1980 are, therefore, for the last quarter of the fiscal year only. All costs were computed for whole fiscal years, and were then adjusted for the delayed implementation date. In general, estimates of costs of benefit provisions are the product of four variables: numbers of eligibles; participation rates; costs of benefits per recipient; and federal matching rates. Estimates for the specific variable and the assumptions behind them are detailed below.

CURRENTLY ELIGIBLE CHILDREN

The costs of H.R. 4962 for children already eligible for medicaid derive from three sources: (1) the costs of benefit improvements, in-

cluding the prohibitions of cost-sharing and of limitations on the amount, duration, or scope of services; (2) the costs of assessments and follow-up diagnosis and treatment; and (3) the costs of increased federal matching for ambulatory services for children appropriately assessed and treated.

The benefit improvements are estimated to raise by approximately three percent (from $312 to $321) the projected average annual medicaid expenditure per recipient under age 21. The bill would mandate coverage of assessments, immunizations, clinic services, diagnosis and treatment of vision and hearing problems, prescribed drugs, prosthetic devices, home health services, physical therapy, rehabilitative services, routine dental care, and certain mental health services. A majority of states already cover most of these services. Relatively few states, accounting for only about 15 percent of medicaid spending, would be significantly affected by the requirement. CBO assumes that the proposed additional services would raise medicaid expenditures per child by roughly $40 in the affected states. Spread across all states, this amounts to a two percent increase. The prohibitions of cost-sharing and of limitations on the amount, duration, or scope of benefits are assumed to raise cost per child an additional one percent nationally.

On the basis of the most recent monthly medicaid data, CBO estimates that an assessment would cost about $25 in fiscal year 1980. CBO further assumes that, for a child screened for the first time, screening would raise by 25 percent the medical costs incurred during the year following screening. Estimates of the costs of CHAP services are necessarily crude because good estimates of EPSDT costs are unavailable. Although states can keep track of the costs of the medical examination that is the first stage of the EPSDT process, they cannot segregate the costs of assessment-related medical care from those costs that would have been incurred in the absence of assessment. CBO's estimate of incremental CHAP costs is based on a 1978 study of EPSDT costs done for the Health Care Financing Administration (HCFA) and on an unofficial HCFA estimate of the cost of the EPSDT program in fiscal year 1977. CBO's estimate assumes more thorough screening and follow-up care under CHAP than is currently the case under EPSDT. Medicaid data indicate that 52 percent of screened children today require treatment for at least one medical problem. But, this percentage varies from 4 percent in Massachusetts to 99 percent in Montana, a range attributable partly to differences in the efficacy of individual state EPSDT programs. Moreover, a study of EPSDT by the Children's Defense Fund concluded that only about 60 percent of the medical problems discovered by screening are ever treated. The performance incentives in H.R. 4962 should make CHAP programs more efficacious generally than EPSDT programs today.

CBO assumes that assessments after the first one augment medical costs by about 5 percent. In those years in which a previously screened child is not scheduled for assessment, it is assumed that medical costs are approximately 2 percent higher than they would have been had the child never been assessed. These assumptions are made in the absence of any data regarding these costs. It seems unlikely that subsequent screens would be as expensive as the first one: fewer and less serious problems should be discovered. On the other hand, some

additional medical costs are expected even in years in which no assessment is made, including costs reflecting improved rapport with the medical system.

The bill would raise by 25 percentage points (up to a 90 percent maximum) the federal share of expenditures for assessments and ambulatory services for most appropriately assessed and treated children. For children covered under continuing care agreements, the federal share of the same expenditures would be increased by 30 percentage points (up to a maximum 95 percent federal share). The average federal share of medicaid medical payments today is 56 percent. Because few children are expected to be covered by continuing care agreements in fiscal year 1980, the federal share of the costs of assessments and ambulatory services for assessed children is estimated to increase from 56 to 81 percent. Since ambulatory services constitute about 55 percent of medicaid payments for children, the average federal share of medicaid payments for all medical care for assessed children is estimated to be 70 percent (0.55 times 81 plus 0.45 times 56). The costs of follow-up medical care are assumed to be matched at the higher rate for ambulatory services, since most follow-up care is ambulatory.

Costs for currently eligible children are calculated on a base of 12.9 million eligibles and 8.3 million beneficiaries. These estimates exclude children 18 to 20 years old in states that presently restrict medicaid to children in families receiving cash assistance. It is assumed that those states will not elect to provide CHAP benefits for children over age 17. The estimates also omit medically needy children. Few, if any, of these children are assumed to be screened and treated under CHAP.

Because it is difficult to predict the effects of the bill's outreach requirements, no increase is assumed in the proportion of currently eligible children who actually receive some medicaid benefits. If those requirements succeed in increasing that proportion, then costs would exceed the estimates shown.

CBO's evaluation of the incentives in the bill indicates that H.R. 4962 would increase dramatically the proportion of medicaid recipient children who are assessed and treated under CHAP. Incentives for assessment are of two kinds: (1) higher federal matching and, therefore, lower state expenditures for ambulatory medical care for assessed children; and (2) financial bonuses and penalties based on the proportion of medicaid recipient children properly assessed and treated. In every state, the higher federal matching alone would provide a strong financial incentive to assess and treat medicaid recipient children. The costs of providing these additional services would be far outweighed by the reduced state share of medicaid expenditures for services that would have been provided anyway. Consequently, CBO expects that the states would strive to assess children already receiving medicaid benefits. For the first five years of the program, CBO assumes that 40, 55, 70, 80, and 84 percent of enrolled children would receive CHAP benefits. About 30 percent of such children receive EPSDT benefits today. The maximum CHAP participation rate (84 percent) is assumed to be the same as the proportion of AFDC children now obtaining medicaid benefits.

NEWLY ELIGIBLE CHILDREN

CBO estimates that another 5.0 million children would become eligible for medicaid under the provisions of H.R. 4962. The bill would require coverage for all children under age 18 who are members of families whose incomes are less than the applicable state medicaid standard—regardless of whether their families receive cash assistance. This would add about 4.1 million children. The bill would also mandate coverage for children in families whose incomes are above state medicaid standards but below two-thirds of the federal poverty level. This is estimated to make eligible another 900,000 children. All estimates are derived from a simulation of the current and proposed rules governing medicaid eligibility. The simulation employs information on income and family characteristics from the 1976 Survey of Income and Education.

The proportion of newly eligible children who actually obtain some medicaid benefits during the year is assumed to rise gradually to the level of participation of non-AFDC children currently eligible for medicaid. Thus, for these estimates, participation rises from 8 percent in the first year to 33 percent in the fifth year of the program, and the estimated number of additional recipients climbs from 0.4 million to almost 1.7 million children.

The average cost for new recipient children is estimated to be $279 in fiscal year 1980. The estimate includes the impact of the benefit changes proposed in the bill. The figure is somewhat lower than the average cost for current recipient children, reflecting the distribution of new recipients among the states. An estimated 14 states would not experience increases in recipients under the bill. These states, typically higher cost states, already cover non-AFDC children and are expected to have medicaid income standards above two-thirds of the poverty level.

The average federal matching rate in the affected states is computed to be 61 percent, which is five percentage points higher than the average for all states. The average federal share of expenditures for ambulatory services for assessed children is correspondingly higher too. The higher matching rates reflect the impact on the medicaid matching formula of the lower-than-average incomes per capita in those states.

PREGNANT WOMEN

H.R. 4962 would mandate medicaid coverage during pregnancy and for two months after delivery for women whose incomes are less than either 80 percent of the poverty level or the appropriate state medicaid standard. CBO estimates that 220,000 additional women would gain medicaid eligibility during pregnancy under this provision. The estimate is derived from a simulation of the medicaid eligibility rules using information on income and family characteristics from the 1976 Survey of Income and Education.

Participation is assumed to rise from 16 percent of newly eligible women in the first year to 67 percent in the fifth year of the program. The number of new recipients would therefore climb from about 36,000

to almost 150,000 after 5 years. The participation rates are somewhat arbitrary. The assumed maximum rate is about midway between estimates of the current participation rate for medicaid eligibles receiving cash assistance and that for medicaid eligibles not receiving cash assistance (excluding the medically needy). Non-AFDC women are unlikely to be as aware of the availability of medicaid benefits as AFDC women. At the same time, because of the certainty of her condition, a pregnant woman would probably be more likely to obtain benefits during pregnancy than the typical medicaid eligible who does not receive cash assistance.

In fiscal year 1980, the average cost of pregnancy, including two months of baby care, is projected to be $2,100. This estimate is derived from a variety of published and unpublished sources. The additional medicaid cost is reduced to $1,400 for single women pregnant for the first time whose incomes are below AFDC standards. Such women are assumed to become eligible for both AFDC and medicaid immediately after delivery. As a consequence, based on information provided by HEW, it is assumed that about one-third of the costs of pregnancy would be borne by medicaid even without the proposed change. Based on the eligibility simulation, about 60,000 of the additional women would qualify for AFDC and medicaid after delivery. The weighted average additional medicaid expenditure per pregnancy for all newly eligible women is therefore a little more than $1,900.

Costs for this provision are the product of new eligibles, participation rates, the weighted average medicaid cost per pregnancy, and the average federal share of costs (56 percent).

EIGIBILITY EXTENSIONS

Currently, if an AFDC family loses its eligibility because of increased earnings, its members retain eligibility for medicaid for four months. H.R. 4962 would broaden that protection of medicaid eligibility by including any losses of AFDC eligibility because of increased income or resources. In addition, it would extend that protection to all medicaid eligible children who would otherwise become ineligible because of increased income or resources. For this provision, the estimates shown are HEW estimates of costs that have been reviewed by CBO.

The bill also includes two special additional extensions of medicaid eligibility for children who would otherwise lose their eligibility because of increased income or resources. The medicaid eligibility of a child with a correctable medical condition would be extended until the condition is corrected. The medicaid eligibility of a child with controllable medical condition, such as diabetes or epilepsy, would be extended for one year. Each year almost 9 percent of AFDC families lose their eligibility because of increased income or resources. CBO's estimates of the costs of these eligibility extensions assume that that percentage applies similarly to non-AFDC children eligible for medicaid. Assuming that one percent of children who would otherwise lose their eligibility have correctable medical conditions that would not be corrected within four months, and assuming that the average cost of treatment continued beyond four months is $100, the cost of extending the medicaid eligibility of children with correctable medical conditions is

estimated to be about $0.5 million annually. On the basis of information provided by the American Diabetes Association and the Epilepsy Foundation, CBO estimates that the eligibility extension for children with controllable conditions would cost about $4 million annually.

MENTAL BENEFITS

The bill would require coverage for children of (1) ambulatory mental health services provided in community mental health centers or other approved clinics and (2) "emergency crisis intervention inpatient mental health services." The estimated costs shown are based on HEW estimates of the costs of the required ambulatory mental health services. The HEW estimates are arbitrarily increased by 10 percent to account for emergency inpatient services. Cost increases in fiscal years after 1980 reflect medical price increases, growth of the recipient population, and the increasing federal share of costs as a growing proportion of recipients are assessed and treated.

ADOPTED CHILDREN

H.R. 4962 would allow states to provide medicaid coverage for children placed for adoption whose requirements for continuing medical care reduce the likelihood of adoption. At the option of the states, coverage could be limited to treatment of specific medical problems only, or it could be unrestricted. The provision would apply only to children placed for adoption after enactment of the bill.

The costs of this provision are probably very small. Medicaid coverage would be provided only for children who would not otherwise be adopted. Few such cases are anticipated. In addition, new federal costs would be incurred only when medicaid benefits are provided for an adopted child who was not receiving them before adoption. Although evidence is scanty, it is commonly believed that a sizable proportion of children in foster care—children receiving AFDC foster care, for example—are eligible for medicaid.

INSTITUTIONALIZED CHILDREN

The bill would allow the states to extend medicaid coverage to children who are residents of nonmedical, publicly supported institutions, like reformatories and halfway houses. The estimated costs shown are based on an HEW estimate for thep rovision for fiscal year 1979. Costs for fiscal year 1980 and beyond are obtained by inflating the HEW figure using CBO's projected rates of increase in medical care prices.

RESIDENCY

The bill would substitute the words "who are determined to be living in the state" for the words "who are residents of the state" in Section 1902(a)(16) of Title XIX of the Social Security Act. The effect of the change would be to expand medicaid coverage to some migrant families that do not presently meet state residency requirements for medicaid eligibility. CBO's estimates of the costs of this provision are derived from figures contained in the Administration's budget for fiscal year 1980. Estimates for subsequent years are obtained

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by inflating the Administration's figure by CBO's projected increases in medical care prices.

STUDIES

The bill would require that four studies be undertaken: (1) a study of the medicaid participation rate of children eligible for medicaid in each state; (2) a study of duplication among federal health programs serving mothers and children; (3) a study of ways to encourage participation in the CHAP program of various providers of health care; and (4) a study of the effectiveness of the CHAP program. The studies of medicaid participation and of CHAP efficacy would be continuing studies. The duplication study would be completed by two years after enactment and the study of participation of providers by October 1, 1983. The bill would require that one-eighth of one percent of medicaid appropriations for ambulatory services for children be spent to study the effectiveness of the CHAP program. This amount is estimated to be about $2 million in fiscal year 1980. Aggregate costs for the other studies are estimated to be less than $0.5 million in any year. Costs in fiscal year 1980 are assumed to be less than $0.5 million because of the lead-time required to commence such studies.

ADMINISTRATION

The administrative costs shown are the federal share of estimated state expenditures for administering medicaid. They include the costs of outreach and follow-up efforts in addition to ordinary administrative expenses. For medicaid generally, total administrative costs are currently slightly over six percent of benefit payments, but this proportion is growing 5.5 percent annually. Total administrative costs exclusive of outreach and follow-up are obtained by multiplying costs of new benefits by the projected ratios of administrative costs to benefit costs. The federal share of these costs is about 60 percent.

It is assumed that outreach efforts will be directed towards medicaid recipients rather than medicaid eligibles. Costs for home outreach visits are assumed to be $14 for two hours per two-child family. Costs for telephone outreach are assumed to be $1 per call with two calls per two-child family. It is assumed that 20, 40, 40, 33, and 33 percent of families will be visited and 0, 20, 60, 67, and 67 percent will be telephoned in the first five years after implementation of the act. These assumptions, which are fairly arbitrary, yield outreach costs per recipient child of $1.40 in the first year and $3.00 in the fifth year of the CHAP program. The federal government would reimburse 75 percent of these costs.

Follow-up costs would be incurred only for children who are assessed and referred for treatment of a medical problem. For this estimate, it is assumed that 75 percent of assessed children would be referred for treatment. Current costs for follow-up are estimated to be about $10 per referred child. Under CHAP, because increased federal matching would be available only for assessed children who receive any necessary follow-up treatment, increased follow-up efforts are assumed to raise this cost by 50 percent. The estimated costs shown include an adjustment for the increased federal matching for current follow-up expenditures.

BONUSES

The bill would establish a system of performance-related bonuses and penalties in the form of adjustments to the federal share of state medicaid administrative costs. The measure of performance would be the fraction of medicaid-enrolled children who are appropriately assessed and treated. In computing the ratio, children covered by continuing care agreements would be counted 1.2 times. If performance were below 25 percent, a penalty would be assessed. If it were above 50 percent, a bonus would be awarded. The penalty would be a 20 percent reduction in the federal share of most state expenditures for administration of medicaid. The bonus would be a one percent increase (up to 25 percent) in the federal share of most administrative costs for every two percentage points by which a state's performance exceeds 50 percent.

It is assumed that no penalties would be assessed. The minimum performance level is five percentage points below the current proportion of enrolled children who receive EPSDT benefits. As discussed earlier, the bill's strong incentives are expected to raise that proportion dramatically. Although it might be argued that some states would lag behind the rest, the penalty provision would not become effective until twenty-seven months after enactment.

The costs of bonuses are calculated using the CHAP participation rates that were employed in the calculation of costs of benefits for children. Thus, in fiscal year 1984, the average bonus is estimated to be 17 percent (one-half of 84 percent minus 50 percent). Estimates of federal expenditures for state medicaid administrative costs are based on the estimate for fiscal year 1980 contained in the Administration's 1980 budget. That figure is inflated at CBO's estimated rates of increase in medicaid spending to obtain estimates for future years. Because the bonus provision would become effective in the first calendar quarter beginning at least 15 months after enactment, no costs are shown for fiscal year 1980, and those for fiscal year 1981 are for two quarters only.

STATE IMPACT

CBO estimates that H.R. 4962 would lower aggregate state medicaid expenditures. Estimates of savings are shown below.

Estimated State savings (fiscal year):	*Millions*
1980	—$5
1981	—$7
1982	—$52
1983	—$71
1984	—$74

Some of the provisions of the bill would result in substantial savings for some states. Other provisions would raise costs in all states. The changing interplay of the frequently offsetting effects of the various provisions make statements about the net impact on particular states speculative.

7. Estimate comparison: None.
8. Previous CBO estimate: None.
9. Estimate prepared by: Malcolm J. Curtis (225–7766).
10. Estimate approved by:

James L. Blum,
Assistant Director for Budget Analysis.

Agency Reports

Agency reports were requested on H.R. 2159, H.R. 2461, and H.R. 4053, predecessors to H.R. 4962 which were similar in coverage and approach. Favorable reports were received on H.R. 4053, a bill which was identical to draft legislation submitted by the President to the Congress on May 10, 1979, from the Department of Health, Education, and Welfare and from the Office of Management and Budget. No reports were received on other bills to establish a child health assurance program.

Department of Health, Education, and Welfare,

July 10, 1979.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your request for a report on H.R. 4053, the "Child Health Assurance Act of 1979."

We transmitted the bill to the Congress, on behalf of the Administration, on May 10, 1979, with accompanying explanatory materials, and urged that it be promptly and favorable considered.

We are advised by the Office of Management and Budget that the bill's enactment would be in accord with the program of the President.

Sincerely,

Joseph A. Califano,
Secretary.

Executive Office of the President,
Office of Management and Budget,
Washington, D.C., July 13, 1979.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your request of June 15, 1979 for the views of this Office on H.R. 4053, a bill "To strengthen and improve medicaid services to low-income children and pregnant women, and for other purposes."

H.R. 4053 is identical to draft legislation submitted by the Secretary of Health, Education, and Welfare on May 10, 1979. The bill would authorize HEW to carry out a new expanded program of health screening and treatment for children of poor families by replacing the current Medicaid Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) with a new Child Health Assurance Program (CHAP).

We concur with the views expressed by the Secretary of Health, Education, and Welfare in his transmittal letter. Accordingly, we recommend that the Committee give favorable consideration to the bill. Enactment of H.R. 4053 would be in accord with the program of the President.

Sincerely,

Naomi R. Sweeney,
Acting Assistant Director for Legislative Reference.

Section-by-Section Analysis

SHORT TITLE

Section 1 establishes the short title as the Child Health Assurance Act of 1979.

PURPOSE

Section 2 states the general purposes of the program established by the Act.

ELIGIBILITY PROVISIONS

The amendments to title XIX of the Social Security Act contained in subsection (a) of Section 3 require a State to provide medical assistance to any child under 18 if the income of the child's family is less than the State's eligibility standard for Medicaid or the national CHAP income standard, whichever is higher, and the resources of the family do not exceed the State's resource standard for Medicaid. A State has the option to extend this coverage to children up to 21.

The amendments of the subsection also require a State to provide medical assistance to a pregnant woman if the income of the woman (or the family of which she is a member) is less than the State's eligibility standard for Medicaid or the national maternal income standard, whichever is higher, and her resources do not exceed the State's resource standard for Medicaid.

The amendments to title XIX contained in subsection (b) of Section 3 specify that services provided to a pregnant woman during her pregnancy and the 60 days thereafter (and to any child born as a result of the pregnancy for those 60 days) will be considered medical assistance for purposes of receiving Federal matching funds, provided the woman is eligible on the basis of her income and resources, except that services provided to a woman for the 60 days after her pregnancy is terminated by an abortion will not be considered medical assistance unless the abortion was performed to save the life of the mother or to terminate a pregnancy resulting from rape or incest, or unless the woman is eligible under title XIX on some other basis than her pregnancy.

The amendments of the subsection also specify that services provided to an adopted child with special needs will be considered medical assistance for purposes of receiving Federal matching, regardless of the income and resources of the adopting family, as well as services provided to an individual under the age of 21 if the income of the individual's family is less than the CHAP income standard.

The amendments to title XIX contained in subsection (c) of Section 3 specify that the national CHAP income standard will be two-thirds of the nonfarm income official poverty line as defined by OMB for the appropriate family size, and that the national maternal income

standard will be 80 percent of the poverty line for the appropriate family size.

The amendments of the subsection specify that income-related expenses should be considered and disregarded in the same manner as they are considered and disregarded in determining eligibility for the State's AFDC program.

The amendments to title XIX contained in subsection (d) of Section 3 define an adopted child with special needs as an individual who is under the age of 18 (or 21, if the State opts to cover children up to this age) who was in foster care and has been placed for adoption, and who suffers from a medical or handicapping condition requiring continuing medical care which contributed to making the child difficult to place for adoption. The State may make such an individual eligible for all medical assistance included in the State Medicaid plan, or only for medical assistance required to treat the condition. The State may continue the eligibility until the child turns 18 (or 21, if children are covered up to 21 in the State Medicaid plan) or until the child no longer needs continuing medical care to treat the condition.

The amendments to title XIX contained in subsection (e) of Section 3 define the term "outreach" as the identification of eligible children and pregnant women, and the provision of information to such individuals concerning their Medicaid eligibility, and require that a State allocate a reasonable proportion of program funds to outreach activities for pregnant women.

The amendments to title XIX contained in subsection (f) of Section 3 are technical in nature.

REQUIRED SERVICES

The amendments to title XIX contained in subsection (a) of Section 4 specify that a State may not limit the amount, duration or scope of services that are required for children under 21. The amendments of the subsection specify that pregnant women are eligible for all Medicaid services which are maindated for cash assistance recipients.

The amendment to title XIX contained in subsection (b) of Section 4 is technical.

The amendments to title XIX contained in subsection (c) of Section 4 specify the services which are required to be covered for eligible children under 21.

In addition to service otherwise required under Medicaid, the following services are mandated for eligible children: child health assessments and continuing care, immunizations, clinic services, diagnosis and treatment of vision and hearing problems (including hearing aids and eyeglasses), prescribed drugs and insulin, prosthetic devices, home health services, physical therapy, rehabilitative services, ambulatory mental health services delivered in centers meeting standards routine dental care, and emergency crisis intervention inpatient mental health services.

The amendments of the subsection also require States to cover prenatal and postnatal services under Medicaid.

The amendments to title XIX contained in subsection (d) of Section 4 specify that Federal matching funds are not available for costs of

dental screening which is separate and apart from the provision of routine dental care.

CHAP REQUIREMENTS

The amendments to title XIX contained in subsection (d) of Section 5 establish the structure for a Child Health Assurance Program. The subsection provides that child health assessments must be made available to all children under 21 who are eligible for medical assistance under the State plan, and that such assessments must include such procedures at such intervals as the Secretary specifies.

The assessments must be provided either by a continuing care provider who has agreed to provide assessments and primary care to a specific child, by a health care provider who has signed a general agreement, or by a physician who certifies the assessment was carried out in accord with all necessary requirements. The provider who does assessments must agree to provide basic diagnostic and treatment services (such as immunizations), to refer for necessary services (including dental care) to provide them, to do or contract for follow-up, or provide information to the State so follow-up can be done, and to manage the medical care for the child.

The amendments of the subsection specify a range of providers included within the definition of a health care provider, including physicians, HMOs, health centers, and others. They define a continuing care provider as one who signs a child-specific agreement to do assessments, referral, and follow-up and to provide primary and preventive care on a continuing basis.

The amendments of the subsection provide the Secretary with general authority to establish standards for payments to continuing care providers, and require a State to reimburse HMOs for services to children at a rate determined to be 95 percent of the average expenditure for medical assistance to a child in the State.

The amendments of the subsection require States to prepare and disseminate a list of dentists who agree to provide services to Medicaid children, and to assure the compliance of health care providers with their agreements, and provide the authority to require uniform claim forms for providers of assessments and ambulatory services to children.

The amendments to title XIX contained in subsection (b) of Section 5 require each State to develop a plan for implementation of CHAP, with substantial public input. A State is required to identify and make provision for agreements with all qualified health care providers who will do assessments or continuing care, to reimburse at levels which can reasonably be expected to elicit adequate participation by providers, and to allocate a reasonable portion of program funds for outreach services to poor children, and follow-up services where necessary.

COPAYMENTS

The amendments to title XIX contained in Section 6 provide that children under 21 and pregnant women are not required to pay copayments for any mandatory service, and only nominal copayments on optional services.

CONTINUATION OF ELIGIBILITY

The amendments to title XIX contained in Section 7 provide for a 4-month extension of Medicaid coverage for any child who would otherwise become ineligible because of an increase in the family's income or resources, except that for a child with a medical condition which is not correctable but which can be controlled or stabilized with treatment, the extension of eligibility is for 12 months. The amendments provide for an additional extension of Medicaid eligibility for a child with a correctable medical condition until that condition is corrected.

The amendments of the section also provide that a pregnant woman will remain eligible throughout the course of her pregnancy, and (along with any child born as a result of the pregnancy) for 60 days thereafter, regardless of any changes in her income or resources, except that the 60 days of coverage after termination of pregnancy will not apply to any woman whose pregnancy was terminated by an abortion unless the abortion was performed to save the life of the mother or to terminate a pregnancy resulting from rape or incest, or unless the woman is eligible under title XIX on some basis other than her pregnancy.

FEDERAL MATCHING FOR CHAP

The amendments to title XIX contained in subsection (a) of Section 8 provide that the costs of outreach and follow-up will be matched as administrative costs at a rate of 75 percent.

The amendments to title XIX contained in subsection (b) of Section 8 provide for an increase in the Federal matching rate for assessments, and for all non-inpatient services provided to children who have a current assessment. The new Federal matching rate is calculated by adding 25 percentage points to the current matching rate for each State, up to a maximum Federal matching rate of 90 percent, except for children who are enrolled with a continuing care provider, in which case the increase is 30 percentage points, up to a maximum rate of 95 percent.

The amendments to title XIX contained in subsection (c) of Section 8 provide that the Federal share of administrative costs for the Medicaid program will be increased on a graduated basis, up to a maximum of 25 percent, for a State which exceeds a reasonable level of performance in its CHAP program. The amendments of the subsection also provide that a State will be penalized by a loss of 20 percent of the Federal share of its administrative costs if its CHAP performance is less than the minimum level established by the Secretary. Imposition of the penalty can be postponed for six months if a State takes steps to correct its performance, and may be waived in whole or part if the State achieves the minimum level at the end of that time.

The amendments of the subsection provide that performance will be determined by the ratio of total number of children who

(1) are in continuing care and receive necessary services,

(2) received an assessment and necessary treatment, or

(3) were not due for an assessment and did not need treatment

to the number of all children enrolled in Medicaid. Additional credit

is given for children in continuing care (having 5 children in continuing care is counted as equivalent to 6 children with current assessments). The level of minimum performance is established at a ratio of 1 to 4 (25 percent) and the level for reasonable performance at 1 to 2 (50 percent).

The amendments of the subsection provide for use of a valid random sample to determine performance, and require the Secretary to report State performance to the Congress.

Subsection (d) of Section 8 directs the Secretary to study the relationship of the proportion of children enrolled in Medicaid to the number of low-income children in a State, and to evaluate the effectiveness of a performance standard based on enrolled children. If the study demonstrates that the ratio of enrolled children to poor children in a State is substantially below the average for all States, the Secretary is directed (1) to require a State to submit a satisfactory plan for outreach or (2) if necessary, to undertake outreach activities in the State.

Subsection (e) of Section 8 provides that an individual screened under the requirements of the current law shall be considered to have had a child health assessment if conditions established by the Secretary in regulations are met.

MAINTENANCE OF EFFORT

The amendments to title XIX contained in Section 9 require a maintenance of effort by States regarding services for and coverage of children, as a condition for receiving the higher Federal matching rate; that is, they may not lower their eligibility standards or discontinue services for children during the first four years the higher matching rate is available.

PENALTY PROVISION OF CURRENT LAW

Section 10 provides that the reductions in payment for failing to meet EPSDT requirements of current law will not be made for quarters prior to the effective date of publication of final regulations published after January, 1979. The amendments to title IV of the Social Security Act contained in Section 10 repeal those penalty provisions when CHAP becomes effective, and require States to inform AFDC families about CHAP.

RESIDENCY

The amendments to title XIX contained in Section 11 clarify the Secretary's authority to determine State of residence for purposes of Medicaid coverage where intent-to-reside is at issue, and provide that Medicaid is available only to persons with U.S. citizenship or who have been lawfully admitted for permanent residency.

STUDY OF DUPLICATION OF SERVICES

Section 12 requires the Secretary to study the duplication of CHAP, title V and other programs for children, and recommend ways to reduce duplication where it is inappropriate and improve coordination.

STUDIES OF PROVIDER PARTICIPATION

Section 13 directs the Secretary to conduct studies and demonstrations of ways to improve provider participation in CHAP, and to determine the impact of capitation payments.

STUDY OF EFFECTIVENESS OF CHAP

Section 14 directs the Secretary to conduct ongoing studies of the effect of preventive and primary care services provided under CHAP, the incidence of disorders uncovered, and the cost of identifying the disorders.

CHILDREN IN PUBLIC INSTITUTIONS

The amendments to title XIX contained in Section 15 allow States the option of providing Medicaid coverage to children in public institutions if they were eligible before entry into the facility, or if the individual's family would be eligible if the individual was residing with the family.

EFFECTIVE DATES

Section 16 establishes effective dates for the provisions of the Act. The amendments relating to CHAP are effective the first calendar quarter beginning at least six months after the date of enactment, or July 1, 1980, whichever is later. It further provides that if legislative action is required to change a State plan for medical assistance to meet the requirements of the Act, the State plan will not be considered out of compliance with the requirements of the law resulting from this Act before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.

Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

Part A—Aid to Families With Dependent Children

STATE PLANS FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN

Sec. 402. (a) A State plan for aid and services to needy families with children must—

(1) * * *

* * * * * * *

(17) provide that the State agency shall inform all families in the State receiving aid to families with dependent children of the availability of child health assurance services under the plan of such State approved under title XIX;

* * * * * * *

PAYMENT TO STATES

SEC. 403. (a) * * *

* * * * * * *

[(g) Notwithstanding any other provision of this section, the amount payable to any State under this part for quarters in a fiscal year shall with respect to quarters in fiscal years beginning after June 30, 1974, be reduced by 1 per centum (calculated without regard to any reduction under section 403(f)) of such amount if such State fails to—

[(1) inform all families in the State receiving aid to families with dependent children under the plan of the State approved under this part of the availability of child health screening services under the plan of such State approved under title XIX,

[(2) provide or arrange for the provision of such screening services in all cases where they are requested, or

[(3) arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services.]

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(10) provide—

(A)(i) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI;

(ii) for making medical assistance available to any individual who is under the age of 18 (and, at the option of the State, to any individual over the age of 17 and under the age of 19, 20, or 21 or to any individual who is within a reasonable classification of such individuals)—

(I) if the resources of such individual (including the resources of the family of which he is a member) meet the resources test of eligibility for medical assistance under the State plan approved under this title applicable to a family with dependent children, and

(II) if the income of such individual (including the income of the family of which he is a member) does not exceed the higher of the income test for a family with dependent children to be eligible for medical assistance under the State plan or the national child health assurance program income standard established under section 1902(d);

(iii) for making medical assistance available to any woman for a period of her pregnancy and 60 days following the date of the termination of her pregnancy if the pregnancy terminated as a result of a birth, miscarriage, or an abortion performed to save the life of the mother or to terminate a pregnancy resulting from rape or incest and for making medical assistance available, for 60 days following such date, to any child born as the result of such pregnancy—

(I) if the resources of such woman (including the resources of the family of which she is a member) meet the resources test of eligibility for medical assistance under the State plan approved under this title applicable to a family with depedent children, and

(II) if the income of such woman (including the income of the family of which she is a member) does not exceed the higher of the income standard for such a woman to be eligible for any medical assistance under the State plan or the national maternal income standard established under section 1902(d);

(B) that the medical assistance made available to any individual described in [clause] *subparagraph* (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in [clause] *subparagraph* (A); and

(C) if medical assistance is included for any group of individuals who are not described in [clause] *subparagraph* (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under title XVI, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in [clause] *subparagraph* (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) *or services described in paragraph (13) (A) (iii)* to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreeemnt entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, [and] (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in [clause] *subparagraph* (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in [clause] *subparagraph (A), and (IV) in the case of adopted children with special needs, a State may limit medical assistance to such children to medical assistance for a condition described in section 1905(m)(4);*

* * * * * * *

(13) provide—

(A) (i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(iii) in the case of any individual described in paragraph (10)(A) and under the age of 18 (and where the State exercises the option under paragraph (10)(A)(ii), to individuals under the age of 19, 20, or 21) for inclusion of the care and services listed in paragraphs (1) through (5) of section 1905 (a) without limitation on the amount, duration, or scope of medical assistance, and

[(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and]

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(B) in the case of any individual described in clause (i) or (iii) of paragraph (10)(A), for the inclusion of at least the care and services listed in paragraphs (1) through (5) of section 1905(a), and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in [clauses] *paragraphs* (1) through (5) of section 1905(a) or

(ii)(I) the care and services listed in any 7 of the [clauses numbered] *paragraphs* (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such facility, and

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII; and

* * * * * * *

(14) effective January 1, 1973, provide that—

(A) in case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, *,individuals described in clause (ii) or (iii) or paragraph (10)(A)*, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)—

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in [clauses] *paragraphs* (1) through (5) and (7) of section 1905(a), will be imposed under the plan, and

(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and

(B) with respect to individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)) who are not receiving aid or assistance under any such State plan and with respect to whom supplemental security income benefits are not being paid under title XVI and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be,

(i) there may be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, and

(ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal;

* * * * * * *

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions(conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are [residents of] *determined to be living in* the State but are absent therefrom;

(17) include reasonable standards (which, *except as provided under section 1902(d)*, shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or Part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, *or family composition*, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child

who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

* * * * * * *

(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan is notified by the Secretary under section 1862(e)(2)(A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practitioner during the period of the suspension under this title; **[**and**]**

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization**[**.**]**;

(41) assure (through the allocation of a reasonable percentage of program funds and through the use, whenever possible and in accordance with regulations of the Secretary, of nonprofit community-based organizations) the provision of outreach to pregnant women eligible for medical assistance; and

(42) provide that the State will develop, with substantial public input, a plan for the implementation of a child health assurance program described in section 1913 which will meet the minimum level of acceptable performance established under section 1903(r) and which will (A) identify and make provision for agreements with all qualified health care providers willing to enter into agreements described in subsection (b) or (c) of section 1913, (B) make provision for such terms (including terms of prompt payment and adequate reimbursement) as may reasonably be expected to elicit the involvement of health care providers in the child health assurance program, (C) assure coordination between State and local agencies participating in such program and other federally funded programs in the State providing health care services to children, (D) assure (through the allocation of a reasonable percentage of program funds and through the use, whenever possible and in accordance with regulations of the Secretary, of nonprofit community-based organizations) the provi-

sion of outreach to individuals and the provision of followup on the provision of needed care and services and scheduling for and provision of subsequent periodic child health assessments, unless the child health assessment provider or continuing care provider has assumed such responsibility, and (E) describe measures to be taken to reduce duplication of the well-child services provided by other than a health care provider with an agreement under subsection (b) or (c) of section 1913 with those services provided under such program.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes as a condition for eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

[(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 406(a)(2), be a dependent child under part A of subchapter IV of this chapter; or

[(3)] *(2)* any residence requirement which excludes any individual who [resides in the State] *lives in the State (in accordance with standards established by the Secretary)*; or

[(4) any citizenship requirement which excludes any citizen of the United States.]

(3) any citizenship requirement which excludes—

(A) a citizen of the United States, or

(B) an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 203(a)(7) or 212(d)(5) of the Immigration and Nationality Act).

* * * * * * *

(d)(1) For the purpose of establishing the eligibility of and extent of medical assistance provided to certain children and pregnant women, the Secretary shall establish by regulation a national child health assurance program income standard and a national maternal income standard.

(2)(A) The national child health assurance program income standard shall be established for individuals and for each of the family sizes for which a nonfarm income official poverty line, as defined by the Office of Management and Budget, revised annually in accordance with section 624 of the Economic Opportunity Act of 1964, has been established, and the standard for individuals and for family sizes shall be two-thirds of the applicable nonfarm income official poverty line.

(B) The national maternal income standard shall be established for individuals and for each of the family sizes for which a nonfarm income official poverty line, as defined by the Office of Management and Budget, revised annually in accordance with section 624 of the Economic Opportunity Act of 1964, has been established, and the standard for individuals and for family sizes shall be 80 percent of the applicable nonfarm income official poverty line.

(3) In applying the income standards established under paragraph (2), each State shall take into consideration the same income and expenses (including work-related expenses) and disregard the same items of income in the same manner as they would be taken into consideration or disregarded under the State's plan under part A of title IV.

(e) *(1)* Notwithstanding any other provision of this title, effective January 1, 1974, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased [hours of, or increased income from, employment, shall, while a member of such family is employed,] *income or resources or increased hours of employment shall* remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.

(2) Notwithstanding any other provision of this title, each State plan approved under this title must provide (A) that any individual under the age of 18 (or, at State option, any individual under the age of 19, 20, or 21) who becomes ineligible because of increased resources or income for medical assistance under the State plan shall, nonetheless, remain eligible for all medical assistance provided under the State plan to individuals under such age who are otherwise eligible for such assistance until the end of the 4-calendar month period beginning with the month following the month in which the individual became ineligible or, in the case of any such individual with a condition which cannot be corrected through treatment but which can be controlled or stabilized through treatment, until the end of the 12-calendar month period beginning with the month in which the individual became ineligible, and (B) in the case of such an individual—

(i) who, as certified by a physician or other qualified provider and additionally certified by another physician or other qualified provider, has a medical condition which existed on the date the child would but for this paragraph be ineligible for medical assistance and which can be corrected through treatment, and

(ii) for whom a plan of treatment, including an estimate of its duration, has been submitted by the provider making the initial certification to the single State agency which administers or supervises the administration of the State plan,

for continuation of eligibility for medical assistance until such condition is corrected.

(3) Notwithstanding any other provision of this title, each State plan approved under this title must provide that any pregnant woman who is eligible, has applied for, and has received medical assistance under this title and who becomes ineligible for such assistance because of increased income or resources shall, nonetheless, remain eligible for all such medical assistance provided under the State plan until the end of her pregnancy or if the pregnancy terminated as a result of a

birth, miscarriage, or an abortion performed to save the life of the mother or to terminate a pregnancy resulting from rape or incest until the end of the 60-day period beginning on the date of the termination of her pregnancy and that any child born as the result of such pregnancy shall remain eligible for such assistance until the end of such period.

(f) Notwithstanding any other provision of this title, except as provided in subsection (e), no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to [clause] *paragraph* (10) (C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under [clause (10) (A)] *paragraph (10) (A) (i)* of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under [clause (10) (A)] *paragraph (10) (A) (i)* or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under [clause] *paragraph* (10) (C) of that subsection. In States which do not provide medical assistance to individuals pursuant to [clause] *paragraph* (10) (C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under [clause] *paragraph* (10) (A) (*i*) of that subsection.

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966

(1) *except as provided in subsection* (*t*), an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (h) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)(*i*), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII or who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof); plus

(2) *subject to subsection* (*r*), an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel of the State agency or any other public agency; plus

(3) *subject to subsection* (*r*), an amount equal to—

(A)(i) * * *

* * * * * * *

(6) *subject to subsection* (*r*), subject to subsection (b)(3), an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, 1980, with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus ———.

(7) *an amount equal to 75 per centum of sums expended during such quarter which are attributable to outreach and followup services provided in accordance with paragraphs* (*41*) *and* (*42*) *of section 1902*(*a*)*; plus*

[(7)] (8) *subject to subsection* (*r*), an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

* * * * * * *

(f)(1)(A) * * *

* * * * * * *

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under title I, X, XIV or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)(*i*), but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) * * *

* * * * * * *

(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing facility unless such hospital or skilled nursing facility has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital or skilled nursing facility has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k)[.]*; or*

(5) with respect to any amount expended for dental screening apart from the provision of other routine dental care (as defined in section 1905(a)(4)(B)(v)).

* * * * * * *

(r)(1) The amount required to be paid to the State pursuant to paragraphs (2), (3), (6), (7), (8) of subsection (a) for administra-

tion of the State plan shall be adjusted as follows: For each two percentage points by which the level of performance of the State in implementing its child health assurance program under section 1913 exceeds the reasonable level of performance established under subsection (s)(1)(C) such amount shall be increased by 1 percent, except that such amount may not be increased by more than 25 percent. The Secretary shall by regulation provide for a procedure whereby a State agency may demonstrate to the satisfaction of the Secretary, with respect to any period, that it has achieved a performance level which entitles it to a higher amount than the amount determined by Secretary.

(2)(A) If the Secretary determines that a State has failed to have a child health assurance program which meets the minimum level of performance established under subsection (s)(1)(B), the Secretary shall notify the State of such failure and of the fact that the amount required to be paid to the State, with respect to each fiscal quarter beginning after the date of the notification, pursuant to paragraphs (2), (3), (6), and (8) of subsection (a) for administration of the State plan shall, except as provided in subparagraphs (B) and (C), be reduced by 20 percent of that amount until the State shows to the satisfaction of the Secretary that the failure with respect to which the reduction applies has been corrected.

(B) If a State demonstrates to the satisfaction of the Secretary that the State intends to correct a failure established under subparagraph (A), he may withhold the imposition of a reduction under such subparagraph for a period of time (not exceeding six months) to allow the State to fully achieve the minimum level of performance. If, at the end of the period, the Secretary determines that the failure has been corrected, he may waive the imposition of the reduction in whole or in part with respect to the period.

(C) Any State dissastisfied with a determination of the Secretary under subparagraph (A) may, not later than 60 days after the date it was notified of the determination, file a petition with the Secretary for a review of the determination in accordance with procedures established by the Secretary. Such procedures shall provide that such review shall be conducted by an impartial party and shall be completed, and findings and a final determination made, not later than 180 days after the date the State filed its petition for such review.

(s)(1)(A) The level of performance of a State in implementing a child health assurance program under section 1913 is measured by the ratio of—

(i) the individuals under the age of 18 in the State who were covered under an agreement under section 1913(c) for the provision of continuing care services and who received, during the period under review, all necessary care and services covered under such agreement, and

(ii) the individuals under the age of 18 in the State who were not covered under such agreement but who—

(I) received, during the period under review, a timely child health assessment in accordance with section 1913(b) and received in a timely manner after such an assessment (as

specified by the Secretary by regulation) any necessary medical care or treatment for conditions found during such assessment, or

(II) were not due for an assessment and did not need treatment for conditions found during an assessment,

to the total number of individuals under the age of 18 in the State during such period who were enrolled to receive medical assistance under the State plan approved under this title. In determining such ratio, a value of 1.2 shall be given to each individual in the State described in clause (i) and a value of 1.0 shall be given to each individual in the State described in clause (ii).

(B) The minimum level of performance of a State in implementing a child health assurance program under section 1913 is a ratio (as determined under the last sentence of subparagraph (A)) of individuals in the State described in clauses (i) and (ii) of subparagraph (A) to the total number of individuals under the age of 18 in the State who were enrolled to receive medical assistance under the State plan approved under this title which is not less than 25 percent.

(C) The reasonable level of performance of a State in implementing a child health assurance program under section 1913 is a ratio (as determined under the last sentence of subparagraph (A)) of individuals in the State described in clauses (i) and (ii) of subpargraph (A) to the total number of individuals under the age of 18 in the State who were enrolled to receive medical assistance under the State plan approved under this title which is at least 50 percent.

(2) A determination of the level of a State's performance in implementing a child health assurance program under section 1913 shall be (A) conducted at least twice a year, and (B) determined on a random, statistically valid sample. The first sample shall be taken from data from the first 6 months of a State's implementation of section 1913. Each State will cooperate with the Secretary to provide access to documentation needed to make the sample.

(3) The Secretary will annually report to Congress the actual level of performance (as measured under paragraph (1)(A)) of each State in implementing a child health assurance program under section 1913.

(t) If the Secretary determines that a State has taken an action, during a quarter beginning during the four-year period beginning on the date of enactment of the Child Health Assurance Act of 1979, which—

(1) reduces the standard of income or resources for eligibility for medical assistance for individuals under the age of 21 below the applicable standards in existence on the date of the enactment of such Act, or

(2) reduces the amount, duration, or scope of medical assistance (other than inpatient care and services) made available to individuals under the age of 21 below the applicable medical assistance available on such date of enactment,

the Federal medical assistance percentage for such State for child health assesments and for ambulatory services provided to an individual under the age of 21 with a current health assessment under a child health assessment program under section 1913 shall for such quarter be determined under section 1905(b)(1).

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)(i)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are

(i) under the age of 21,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child[, except for section 406(a)(2),] is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI, [or]

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI, *or*

(*viii*) *women during pregnancy and during the 60 days following the date of termination of pregnancy if the pregnancy terminated as a result of a birth, miscarriage, or an abortion performed to save the life of the mother or to terminate a pregnancy resulting from rape or incest and during such 60 days any child born as the result of such pregnancy,*

but whose income and resources are insufficient to meet all of such costs, *or for individuals who are adopted children with special needs (as defined in subsection (m))*—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2)(A) outpatient hospital services, and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (1)) and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individ-

uals 21 years of age or older; [(B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and] *(B) the following services for individuals under the age of 18 (and where the State exercises the option under section 1902(a)(10)(A)(ii), to individuals under the age of 19, 20, or 21): (i) child health assessment services and continuing care services provided in accordance with section 1913, (ii) immunizations, clinic services, diagnosis and treatment of vision and hearing problems, including hearing aids and eyeglasses (whether prescribed by a physician skilled in the diseases of the eye or by an optometrist), prescribed drugs and insulin, prosthetic devices, home health services, physical therapy, and rehabilitative services, (iii) ambulatory mental health services delivered in centers funded under the Community Mental Health Centers Act or meeting standards established by the Secretary in regulations, (iv) emergency crisis intervention inpatient mental health services provided in an accredited psychiatric institution or an institution for mental diseases, and (v) routine dental care (which shall include only diagnostic, preventive, restorative, and emergency dental services and only such orthodontics as the Secretary determines by regulation to be appropriate for different age groups for conditions causing major physical or psychological handicaps); (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and (D) prenatal and post-postnatal services*;

(5) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1902 (a) (31) (A), to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h); and

(17) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16) *and in subsection (o)*, such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well being of such individual. *An individual described in clause (i) of this subsection shall be considered to have income insufficient to meet all of the cost of the care and services described in this subsection if the income of his family does not exceed the national child health assurance program income standard established under section 1902(d), and an individual described in clause (viii) of this subsection shall be considered to have income insufficient to meet all of the cost of the care and services described in this subsection if the income of the individual (and of the family of which the individual is a member) does not exceed the national maternal income standard established under section 1902(d).*

[(b) The term] *(b) (1) Except as provided in paragraph (2), the term* "Federal medical assistance percentage" for any State sall be *100* per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that [1] *(A)* the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and [2] *(B)* the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph, (B) of section 1110(a)(8). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).

(2) The Federal medical assistance percentage for child health assessments and for ambulatory services provided to an individual under the age of 21 with a current health assessment under a child health assurance program under section 1913—

(A) in the case of child health assessments and such services provided to such an individual who is covered under an agreement described in section 1913(c)(1), is the lower of—

(i) the Federal medical assistance percentage determined under paragraph (1) increased by 30 percentage points, or

(ii) 95 percent; and

(B) in the case of child health assessments and such services provided to such an individual who is not covered by such an agreement, is the lower of—

(i) the Federal medical assistance percentage determined under paragraph (1) increased by 25 percentage points, or

(ii) 90 percent.

* * * * * * *

(m) The term "adopted child with special needs" means an individual who—

(1)(A) is under the age of 18, and (B) (at the option of the State) is over the age of 17 and under the age of 19, 20, or 21 or is within a reasonable classification of such individuals;

(2) has been placed for adoption;

(3) was living in foster care immediately before the date of his placement for adoption; and

(4) on the date of the individual's placement for adoption suffered from a condition requiring continuing medical care and services which condition the State determines was a contributing factor to the difficulty of placing the individual for adoption,

but only during the period beginning on the date of the individual's placement for adoption and ending on the date the individual reaches the age specified in paragraph (1) or, at the State's option and if earlier, the date the State determines that the individual no longer requires the continuing care and services described in paragraph (4).

(n) The term "outreach" means (1) the identification and location of families of children eligible for medical assistance under a State plan approved under this title and informing them of the services available under the child health assurance program described in section 1913 and such other actions as the Secretary may prescribe to facilitate the provision of medical assistance to such children, and (2) the identification and location of pregnant women who are eligible for medical assistance and informing them of the prenatal and postnatal and other services available to them and such other actions as the Secretary may prescribe to facilitate the provision of medical assistance for pregnant women.

(o)(1) Notwithstanding subdivision (A) of subsection (a), a State may include, in its plan for medical assistance under this title, payments with respect to care and services for an individual under 21 years of age while the individual is an inmate of a public institution for juveniles if—

(A) the individual, on the day before he became an inmate of the institution, was eligible for medical assistance under the State's plan, or

(B) the family in which the individual resided (on the day before he became an inmate of the institution) was eligible for medical assistance under the State's plan or would be eligible for medical assistance under the State's plan if the individual was still residing with the family.

(2) Notwithstanding paragraphs (10) and (14) of section 1902(a), an individual for whom payment for care and services is provided under paragraph (1) shall be treated under the plan, with respect to the amount, duration, and scope of medical assistance and to fees, premiums, deductions, cost sharing, and other charges—

(A) in the case described in paragraph (1)(A), in the same manner as the individual was treated on the day before he became an inmate of the public institution, or, in the case of such an individual who was eligible for but not provided medical assistance on that day, would have been treated if provided medical assistance on that day, and

(B) in the case described in paragraph (1)(B), in the same manner as the individual would otherwise be treated if still residing with his family.

* * * * * * *

CHILD HEALTH ASSURANCE PROGRAM

SEC. 1913. (a) A child health assurance program under this section must assure the availability to each individual who is under the age of 21 and who is eligible under the State plan to receive medical assistance—

(1) child health assessments in accordance with subsection (b),

(2) the services prescribed by section 1902(a)(13)(iii), and

(3) to the extent practicable, continuing care in accordance with subsection (c).

(b)(1) Child health assessment under a child health assurance program shall include such services and procedures at such periods as the Secretary determines appropriate to determine the health status and identify the health problems of the individual being assessed. A child health assessment may be considered as provided under this section only if the assessment was provided by (A) a physician or other health care provider who enters into a written agreement (described in paragraph (2)) with the single State agency responsible for administering or supervising the administration of the State plan under this title (hereinafter in this section referred to as the "State agency"), (B) a physician who does not enter into such an agreement but who certifies, in a claim made for the assessment, that the assessment was provided in accordance with the applicable requirements of paragraph (2) and that reasonable provisions have been made to meet the other requirements of such paragraph, or (C) a continuing care provider.

(2) The written agreement referred to in paragraph (1) must provide, in accordance with standards established by the Secretary, that the provider agrees as follows:

(A) To provide timely and appropriate child health assessments to individuals under the age of 21 and eligible under the

State plan to receive medical assistance (such individuals hereinafter in this section referred to as "eligible individuals").

(B)(i) To provide directly to eligible individuals whom it has assessed such basic diagnostic and treatment services (including immunization against childhood diseases) as the Secretary shall specify in regulations, or

(ii) to provide to eligible individuals whom it has assessed timely referral to other health care providers for the provision of the basic diagnostic and treatment services referred to in clause (i), and to (I) provide to such individuals followup services which (except with respect to followup services provided by physicians) insure the timely and appropriate provision of the services for which such a referral has been made, (II) enter into agreements with appropriate public agencies and nonprofit community-based agencies for the provision of such followup services, or (III) furnish to the State agency such information as that agency determines to be necessary to allow followup on the provision of needed services.

(C)(i) To provide directly to eligible individuals routine dental care (as defined in section 1905(a)(4)(B)(v)), or

(ii) to provide to eligible individuals whom it has assessed referral to a dentist, from a list provided by the State agency of dentists participating in the child health assurance program.

(D)(i) To refer eligible individuals to appropriate providers for any corrective treatment the need for which is disclosed by an assessment but which is not available directly from the provider, and (ii) to (I) provide to such individuals followup services which (except with respect to followup services provided by physicians) insure the timely and appropriate provision of the treatment for which such a referral has been made, (II) enter into agreements with appropriate public agencies and nonprofit community-based agencies for the provision of such followup service, or (III) furnish to the single State agency that administers, or supervises the administrattion of, the State plan such information as that agency determines to be necessary to allow followup on the provision of needed corrective treatment.

(E) To take responsibility for the management of the medical care of each eligible individual whom it has assessed and to assure that child health assessments are performed on a timely and periodic basis.

(F) To be reasonably accessible on an ongoing basis to eligible individuals whom it has assessed in order to provide continuing medical care or to assure the continuing availability of medical care and services.

(G) To make such reports (i) to the State agency as the agency determines to be necessary to assure compliance with the requirements of the agreement, and (ii) to the Secretary as he determines to be necessary to assure compliance with the requirements of the agreement.

(3) As used in this subsection and section 1902(a)(42), the term "health care provider" includes a physician, public health department, community health clinic or center, primary care center, migrant health center, facilities delivering ambulatory health services and operated

by the Indian Health Service, health maintenance organization, day care or headstart program, rural health clinic, maternal and child health center, school system, and such other providers as may be specified by the Secretary by regulation.

(4) Payment may be made under a State plan to a health care provider for the provision of child health assessments, and other medical care and services to children, under an agreement described in paragraph (2) notwithstanding the fact that the provider does not ordinarily bill other third-party payers for the provision of such assessments, care, and services.

(c)(1) Continuing care services are the services described in subparagraphs (A), (B)(i), (C), (D), (E), (F), and (G) of paragraph (2) and primary and preventive care (including such care services as the Secretary may specify by regulation). For purposes of this section a "continuing care provider" is a health care provider who enters into an agreement with the State agency to provide, in accordance with regulations of the Secretary, continuing care services to a specific individual on a continuing basis.

(2) States shall make payments for continuing care services in accordance with methods and standards meeting such requirements as the Secretary may by regulation prescribe. The Secretary may establish minimum reimbursement levels (which may be uniform nationally or may vary by State or region), may permit payment based on a prospectively determined capitation rate, and payment on a periodic basis, and may permit or require other payment incentives.

(d) In carrying out a child health assurance program under this section, the State agency (1) shall enter into arrangements with health maintenance organizations to provide services to individuals under that program who choose to have such services provided by such organizations, and (2) shall make payments to such organizations for such services at a rate not less than an amount determined by the Secretary to be 95 percent of the average expenditure for medical assistance to individuals under the age of 21 in such State.

(e) The State agency shall prepare and keep current a list of dentists who agree to receive payment for services under the State plan approved under this title and shall provide to each health care provider who has entered into an agreement under subsection (b) or (c) the names of such dentists practicing in the area in which the provider is practicing.

(f) The State agency shall assure the compliance of health care providers who have entered into agreements under subsection (b) or (c) or who have made a certification under subsection (b) with the terms of such agreements or certification.

(g) The Secretary may by regulation require that all providers of child health assessments and other ambulatory health care services under this title to individuals under the age of 21 (or all providers within reasonable classifications of such providers) submit uniform reports and use uniform claim forms.

* * * * * * *

SEPARATE VIEWS ON H.R. 4962—CHILD HEALTH ASSURANCE ACT

On October 16, 1979, the Committee on Interstate and Foreign Commerce ordered reported H.R. 4962, the Child Health Assurance Act of 1979 (CHAP), which is ostensibly designed to strengthen and improve the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program under Title XIX (Medicaid) of the Social Security Act. We oppose this bill on both budgeting and policy grounds hereinafter explained. Furthermore, we deplore the emotional aura shielding this measure, whereby any criticsm of the bill, however justified, is deflected as an inhuman attack on children. The anti-intellectual attempt to immunize CHAP from rational discussion is particularly unfortunate in light of the fact that some of its supporters hail the program as being an aspect of national health insurance.

The administrative problems with the existing program are not considered in the formulation of the new entitlement program.

An issue which has been largely obscured in the emotional debate concerning the relative merits of the CHAP legislation is whether there is any reasonable likelihood that it will be cost beneficial. We do not deny that real needs are attempted to be redressed by this program. But, at the same time, a new entitlement program is created which will provide total health care to millions of people not covered under present law. Rather than pouring out inflated rhetoric about the laudable goals of this program, more attention should have been focused on the failings of and efects in the administration of the present program.

The Social Security Amendments of 1967 (Public Law 90–248) added the EPSDT requirements to Medicaid and ordered screening and treatment for individuals under the age of 21 who are eligible under the state Medicaid program. Many problems exist with the existing program. Examples and documentation of its deficiencies have been furnished by the September 1976 report of the Subcommittee on Oversight and Investigations and by a General Accounting Office report dated January 9, 1975.

Among the observations with respect to EPSDT detailed in the report of the Subcommittee on Oversight and Investigations are the following:

> The Medicaid and Medicare programs are "costing far more than anticipated" and the "explosive rise in costs significantly affects the Federal budget." (page 1)
>
> Appropriate "execution of this program would achieve significant savings by reducing future costs of health care and improving the overall health and productivity of our citizens," but HEW's "failure to faithfully execute EPSDT program results in a waste of dollars as well as human potential." (page 4)

HEW was slow in issuing regulations under EPSDT and "has not taken adequate steps to implement the regulations which it ultimately issued." (page 5)

Deficiencies in public accountability are "widespread within the program." (page 5)

HEW "does not compile data sufficient to allow for effective evaluation or monitoring of the program." (page 5)

Coordination of the EPSDT program is "totally inadequate". (page 6)

On September 9, 1977, Joseph A. Califano, Jr., then Secretary of Health, Education and Welfare, in testifying before the Subcommittee on Health and the Environment on the Administration's initiative seeking to rectify the deficiencies in the EPSDT program, observed with respect to current law, "we have not done our job well at HEW." (page 235 of the printed hearing record)

Regrettably, instead of addressing these legitimate problems with this bill, the Committee has vastly increased the scope of the program while leaving the same bureaucrats in charge. To do this in the fact of the history of maladministration and poor cost/benefit performance for EPSDT shows little concern for the plight of the beleaguered taxpayer who rightly expects his hard-earned tax money to be spent in a cost-beneficial manner.

The program issues a blank check allowing unlimited funds to be drawn from the Treasury.

Even Secretary Califano, in a July 21, 1978 letter (see attachment) to the Chairman of the Health Subcommittee, expressed the opposition of the Administration to several features of the bill reported by the Subcommittee last year because of budget and policy considerations. Detailing these still-valid objections in the letter, in particular he singled out for criticism the unprecedented mandating of a federal income standard for eligibility for this aspect of the Medicaid program. Current law allows each State to establish the income eligibility for its Medicaid program. We believe that this imposition of a policy of uniformity is ill-advised in light of the varying income situations among the several states.

Cost estimates of this legislation were prepared by the Congressional Budget Office and are as follows:

Federal cost, CHAP legislation

Fiscal year:	*Millions*
1980	[1] $131
1981	646
1982	1,123
1983	1,612
1984	1,995

[1] Last quarter of fiscal year 1980 only

In light of the pitiful performance in administering the EPSDT program and in view of our huge deficit, these estimated figures are probably too low. Because these increased costs flow from fundamental changes providing new automatic and uncontrollable entitlements to Medicaid benefits, our Committee will not be embarrassed by having to pass new authorization bills covering these increased costs in future years. However, you can be assured that additional billions of dollars will have to be appropriated to honor these new commitments.

We supported an unsuccessful amendment in Committee which would have converted the program to one based on authorizations of grants to the states. The states could then formulate their own programs. This approach would have encouraged more vigorous oversight and control over expenditures. Unfortunately, the Committee opted for an open-ended concept.

James T. Broyhill,
Samuel L. Devine,
James M. Collins,
Dave Stockman,
W. E. Dannemeyer,

Department of Health, Education and Welfare,
July 21, 1978.

Hon. Paul G. Rogers,
Chairman, Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

Dear Paul: I am pleased to hear that the Subcommittee on Health and the Environment now intends to complete work on H.R. 6706, the Child Health Assessment Act, within the next few days. I am well aware that your commitment on CHAP has remained strong, even though your hectic schedule has caused several unavoidable postponements of final Subcommittee consideration. I'm sure that you share my hope that this vital legislation can now be moved quickly through the Commerce Committee and passed by the full House, so that the Senate has ample time to consider CHAP before the end of the session.

I would also like to take this opportunity to express the Administration's serious concern about the budgetary and policy implications of several amendments the Subcommittee has adopted in concept and will soon be considering in final form. We estimate that these amendments, which are described briefly below, would increase the Federal cost of CHAP almost 100 percent—$264 million over the 1979 budget. By 1983 these amendments will cost an additional $548 [1] million per year. From a policy point of view, these amendments represent significant new departures for Medicaid. Mandating a Federal income standard for eligibility, for example, would be unprecedented for this program. Such changes should be made in the context of overall Medicaid reform or national health insurance rather than piecemeal. On both budget and policy grounds the Administration opposes these additions.

[1] This figure represents a Federal cost of $618 million, less savings of $70 million which would result from the Subcommittee's decision to delay bonus payments for good performance until fiscal year 1981, instead of fiscal year 1980 as in the Administration bill.

The amendments to which we are opposed are as follows:

1. *Establishment of a minimum income floor for children and pregnant women.*—The introduction of a minimum income floor of $4,200 (for a family of four) will extend Medicaid eligibility to an additional 830,000 children and 64,000 pregnant women. We estimate that as many as 276,000 of the children and 16,000 of the pregnant women may become CHAP beneficiaries within the first year at an added Federal cost of $117 million for FY 1979. By 1983 Federal costs would rise to an additional $207 million.

2. *Expanded dental benefits at a higher Federal matching rate.*—The Subcommittee mandated dental coverage for all Medicaid children, waived the requirement for a separate dental screen and provided a higher Federal match for dental services received by assessed children. These changes would add $99 million to estimated Federal CHAP costs in FY 1979. Federal costs would be $264 million by 1983.

3. *Expanded ambulatory mental health benefits at the higher Federal matching rate.*—This amendment requires that States provide ambulatory mental health services to assessed children for the treatment of mental illness, mental retardation and developmental disabilities. This will add an estimated $25 million to Federal CHAP costs in FY 1979, and $55 million by 1983.

4. *Higher matching rate for ambulatory medical services.*—The Federal match for all ambulatory care to assessed children becomes 25 percentage points higher than the State's current rate with a maximum of 90 percent. This amendment will increase Federal costs beyond those projected with CHAP by $23 million for FY 1979, and $92 million by 1983. In our judgment, the expanded matching rate and the reward and penalty provisions included in the Administration proposal are fully adequate to achieve the objective of this legislation. In our view, this amendment would shift State costs to the Federal government with no improvement in program quality.

In closing, I would like to commend you and the members of your Subcommittee for your commitment to improving the health status of poor children through your consideration of this legislation.

I look forward to working with you for the remainder of this session to complete work on CHAP, drug law reform, and the many other important health bills remaining before the 95th Congress. I'm sure you agree that these various bills will lay an essential legislative foundation for the future implementation of a national health program for America.

With best regards,

Sincerely,

DICK WARDEN,
(Joseph A. Califano, Jr.)

ADDITIONAL MINORITY VIEWS OF THE HONORABLE DAVE STOCKMAN

During the course of the Committee's consideration of H.R. 4962, I offered an amendment designed to convert the financing mechanism for the Child Health Assurance program from an open-ended entitlement to one with fixed budget authority subject to the regular appropriations process. Predictably, backers of the bill insisted that my amendment would "gut" the program, notwithstanding the fact that my amendment proposed to authorize $3.4 billion through fiscal year 1983—an amount equal to 90 percent of the CBO-estimated outlays under the Committee's entitlement approach.

I firmly believe, however, that establishing an authorization ceiling on this program is not only desirable but necessary if we wish to extend needed services to low-income women and children without further wrenching apart the integrity of the Congressional budget process. For this reason, I intend to offer a revised version of my amendment once again when CHAP is brought to the floor of the House. In doing so, it is important to set the record straight about what the Stockman amendment to do—and also what it would not do.

THE ISSUE IS NOT THE PROGRAM—IT'S THE FINANCING

It is impossible to refute the evidence that early diagnosis and treatment of disease in low-income children and pregnant women is not only an effective means of reducing human suffering, but is potentially a cost-effective way for the Congress to discharge its commitment to provide adequate medical care for low-income families. By detecting and solving health problems before they become critical, we can simultaneously improve the quality of life for low income children and prevent more costly obligations later on.

It is thus unfortunate that the Committee has chosen to finance these needed services through an open-ended entitlement tacked on to the existing medicaid program.

ENTITLEMENT FINANCING SUFFERS FROM THREE MAJOR FLAWS

There are three major reasons why efforts to reach needy children through open-ended entitlement programs inevitably fail to achieve their intended results.

First, as a purely fiscal matter, it is now obvious to most observers that the Congressional budget and appropriations process is on a fast-track to self-destruction, largely because 75 percent of annual outlays are now uncontrollable in the current year. Consider the spectacle of the FY 1980 budget process. At the time this report is filed, the Conference on the Second Budget Resolution has broken apart without

a salable product. This is not surprising, considering that a majority of the normally-generous Members of this Committee voted 21–17 against its adoption when the resolution was first before the House.

The preponderant share of the swelling uncontrollable portion of the budget is due to the open-ended entitlement programs that are already on the books. Such programs essentially reduce the federal government to the passive role of bookkeeper and bill-payor.

In the last decade alone, outlays for standing entitlement programs have risen astronomically. Since 1970, outlays for Old Age, Survivor & Disability Insurance have climbed from $31.3 billion to over $120 billion, while Unemployment Insurance outlays have climbed from $3.7 billion to $13.2 billion. Public Assistance and Food Stamp outlays have climbed from a modest $4.7 billion to over $26 billion, representing a nearly 19 percent annual rate of increase.

The grand champion entitlement outlay increase, however, is in the area of health care expenditures under medicare and medicaid. From modest beginnings in 1967 with outlays at $4.6 billion, medicare and medicaid outlays have risen tenfold in just 13 years, so that only by doctoring the budget estimates markedly could projected outlays for fiscal year 1980 be held below $50 billion. Over all, if total uncontrollable expenditures keep rising at the present rate—due solely to entitlements already on the books—over 90 percent of the total federal budget will be comprised of uncontrollable expenditures before the turn of the century.

The obvious point is that our proliferating entitlements structure is absolutely inimical to every major Congressional fiscal, budgetary and economic policy responsibility. By the percentage of total federal resources they consume, entitlement programs essentially deny regular ordering of Congressional budgetary priorities, preventing flexible choices on taxes, deficits and outlays. The result is that fiscal policy becomes an outcome of an arithmetic calculation, rather than the product of deliberate choice. In essence, the growing turgescence of the federal budget shifts the whole job of containing monetary growth and managing demand in the macroeconomy over to the Federal Reserve System. The Fed's monetary moves in recent weeks are clearcut evidence of the policy outcome of this shift.

In all, it is absolutely irresponsible to adopt even one single additional entitlement program, no matter how worthy the purpose.

ENTITLEMENT PROGRAMS LEAD TO BACK-DOOR FISCAL CONTROLS

A second major negative consequence of using the entitlement mechanism to fund social programs is that, absent meaningful limitations on the aggregate outlays of the program, the Congress is forced to employ bizzarre ad hoc administrative regulatory campaigns in an effort to hold down costs.

A classic example is the welfare putsch occasioned by the discovery of significant degrees of public assistance overpayments and underpayments nationwide in 1974–74. Not possessed of means of restricting the total flow of dollars into states with the highest error rates, HEW instead resorted to a massive audit of client caseload records that, in

most states, consumed more in administrative costs than was ever recovered in net overpayments.

Similarly, many of the administrative controls currently applied to medicare and medicaid have either shown negligible savings, or backfired completely. Consider the stringent controls on physician fees in the medicaid program. The net result of these efforts has been to cause a significant percentage of all physicians to refuse to deal with the medicaid program. The absurd result is that a significant number of medicaid eligibles receive whatever primary medical care they need in hospital emergency rooms. The net result, of course, is to considerably increase the cost of providing these services to the eligible population.

In all, while the administrative expedients designed to control the otherwise uncontrollable expenditures generated by entitlement programs may occassionally generate short-run savings, they usually do so at the cost of administrative disruptions, meassive increases in monitoring efforts and reporting paperwork, and extensive second-guessing of the clinical decisions of those best qualified to deliver medical care, generating considerably more aggravation than savings.

ENTITLEMENTS PROVIDE LESS "BANG FOR THE BUCK"

That the inexorable rise in costs defies all administrative efforts to contain it is precisely not due to intractable greed on the part of medical care providers. Quite the contrary, entitlement programs, by their very nature, are virtually guaranteed to raise costs out of all proportion to benefits, due to their startling utilization effects.

In 1965, when medicare and medicaid were being debated in the Congress, proponents assured us that outlays under these programs would level off after the access they afforded to quality medical care sufficiently improved the health of the target populations. As a result, it was estimated that total outlays under these programs would stabilize at a level of roughly $17 billion in current 1979 dollars) by 1980.

Unfortunately, outlays under these programs are expected to exceed $50 billion in fiscal year 1980.

This disparity between projected and actual outlays can be accounted for by two main factors. First, provided with wide-open authority to provide whatever health care services were needed by the poor and the aged, hospitals upgraded the quality and quantity of services they offered quite rapidly, resulting in a level of expenditures for hospital care rising far in excess of the overall rate of inflation. Nor were physicians shy about ordering these services. The result is that the medical care "product" provided to the poor and aged is far more sophisticated—and correspondingly more costly—than the product envisioned when the programs were initiated in 1965.

The second, and more general flaw in the entitlement approach is the way in which it completely strips away all incentives for efficient use of resources from all the actors in the system. Whenever possible medical benefits can be achieved, the fact that the cost to the patient and provider is quite often zero ensures that services will almost always be maximized.

In such an incentive structure, it is left to the government as the third party at interest to monitor the total level of health resources

utilization. In the existing medicaid program, the states at least share this responsibility with the federal government. Yet under the bill reported by the Committee, the exceedingly high federal matching rates offered for CHAP services will actually reduce the stake that the state governments have in keeping costs down.

Hence, the sole control authority will devolve on the Health Care Financing Administration within HEW to somehow hold the line on new expenditures under CHAP. As noted earlier, however, the administrative expedients available to HCFA are hardly a source of confidence that costs will be meaningfully controlled. Bereft of the ability to actually control clinical decision-making on the ground, HCFA will be once again forced into the role of "Mr. No," placing ever-tighter regulatory clamps on hapless providers and state welfare caseworkers to keep ineligibles out and unit service prices down. The resultant aggravation of the ability of providers to actually perform the needed services will ensure that any effective remedies are foregone as HCFA relents to the combined effect of the Congressional mandate to provide services and the entitlement financing mechanism.

The result will be a policy circle through which the only consistent trend will be ever-rising costs. Absent more comprehensive efforts to discipline clinical decision-making through price-conscious choice of services, government is fundamentally incapable of controlling the aggregate cost of guaranteeing access to quality medical care through entitlement programs.

THE STOCKMAN AMENDMENT IS THE ONLY EXIT FROM THE MAZE

Acknowledging that the CHAP legislation is not the appropriate vehicle for initiating the more comprehensive reforms that our health care system needs if cost-consciousness is to be restored, I am forced to conclude that only by providing the government—at both the federal and state levels—with real financial leverage can we hope to prevent the program envisioned in this legislation from being caught in a never-ending battle of the sort described above. Only by retaining overall control of the total amount of dollars for which the federal government is liable can we bring pressure to bear to ensure that resources are concentrated on those services we most desire to see performed.

When I offered my amendment in Committee, I sought to establish an authorization ceiling on total new expenditures under the program at a level equal to 90 percent of the amount estimated by CBO to be expended under CHAP if operated as an entitlement program. To my mind, elimination of the entitlement link alone would provide sufficient internal discipline to ensure that the intended level of services was offered to the target population with this dollar amount.

In an effort to accommodate the concerns expressed by a number of my colleagues, however, I intend to revise my amendment to expand the authorization ceiling to 100 percent of the CBO cost estimates, to reflect the reality that, until the CHAP program is fully up and running, the natural inefficiencies attendant on program start-up might make the 90 percent amount insufficient to guarantee that the target population is provided with the intended package of services.

In my original amendment, the complicated performance formulas in the Committee bill were replaced with a simple affirmative duty to expend at least 90 percent of the funds made available in each state in accordance with a plan approved by the Secretary of HEW. While I believe that this approach is far superior to the establishment of complex formulas (the net result of which might be no net service increase at all in a number of states), I intend to revise my amendment to provide adequate assurances to my colleagues that the states will face powerful incentives to perform as Congress intends.

Finally, the realities of limiting the total dollars available require that the states be given some manner of flexibility, in concert with the Secretary, to adjust program activity levels to the dollars available. In my original amendment, this was accomplished by allowing the states considerable latitude to determine the way in which to best target services (over and above the core program of assessments and continuing care) to the eligible population. To respond to a number of concerns expressed by my colleagues, I intend to clarify more full within the language of my amendment the expectation that, given the absolute dollar limits, the states will maximize their service offerings to each eligible person.

In all, I believe that my amendment, as revised, will be a responsible effort to offer my colleagues an opportunity to ensure that needed health care services are provided to low-income pregnant women and children without entering the fiscal and programmatic trap of enacting these services through additional medicaid entitlements. In fact, far from being destructive of the core intent of the CHAP legislation, the Stockman Amendment approach is the only hope to provide these needed services at a reasonable cost.

I urge my colleagues to support it.

Dave Stockman,
Member of Congress.

Representative Dannemeyer's Dissenting Views to H.R. 4962

Proponents of this measure would have the American people believe that the only issue at stake, relative to adoption of H.R. 4962, is improving the quality of health care for pregnant women and poor children. While no one questions the sincerity of their concern, or has any quarrel with the objective of optimum health care for mothers and children, one can legitimately take issue with the methods contemplated for easing that concern and meeting that objective. Not only would adoption of H.R. 4962 substantially increase inflationary deficit spending at a time when inflation is driving up the cost of health care and everything else, but it will accelerate the trend towards bureaucratic rather than physician determination of how patients should be treated. Moreover, in a very real way, it will substitute governmental for parental responsibility in the area of child care.

According to the Congressional Budget Office, the cost of this measure will come to $156 million in fiscal year 1980, $720 million in fiscal year 1981 and $1.213 billion in 1982—an increase of 677 percent in just 3 years. Not only is this a major new expense at a time when we need to be cutting back on federal spending, but given the fact CHAP is an entitlement program and given our past experience with the Medicare and Medicaid entitlement programs, the costs are likely to escalate still further. It might be well to recall that, in the first year of the Medicare and Medicaid programs (fiscal year 1967), outlays came to $3.4 and $2.4 billion respectively, whereas for the fiscal year just closing (fiscal year 1979), expenditures for those two programs are expected to reach the $29.6 and $20.9 billion mark. For Medicaid, of which CHAP will be a part, that represents a 771 percent increase over twelve years, which is another way of saying that it is unlikely CHAP costs will level off after the initial start-up phase.

Given the fact that the projected deficit for fiscal 1980 is in the neighborhood of $30 billion, the inflation rate is pushing 14 percent and the Federal Reserve Board is cracking down on speculative financing, the addition of an open-ended program of such magnitude is difficult to justify. At the very least, H.R. 4962 should be an authorized program with annual or biennial appropriations; preferably, we should stick with the existing EPSDT program until such time as the budget is balanced and inflationary pressures have receded.

If there was any doubt as to the wisdom of such a course, two recent studies should put such doubt to rest. One study, done by U.S. News and World Report, indicates that the growing tax burden in this country has helped produce an underground economy estimated at $200–500 billion. The other, done by the Census Bureau, estimates the increase in federal, state and local taxation from 1971 to 1977 at 59.4 percent and the increase in the federal income tax take during the same period at 70.6 percent. So, while the budget can be balanced and new programs financed by still greater tax increases, the evidence is clear that we

need to go in the other direction. Taxes are too high as it is, what is needed is a cut in spending and a moratorium on new spending proposals. At the head of the list of those programs that could be deferred is CHAP. After all, current law permits the states to provide additional services if they wish; we don't need another federal program to do it for them.

In that context, it should be noted that some states—California is an example—already provide the level of services anticipated by CHAP. Thus CHAP, if enacted, will not help everyone uniformly; rather, it takes from the federal taxpayer and rewards those states which have the least comprehensive programs.

What makes this impetus for CHAP all the more ironic is the knowledge that the aforementioned rapid increase in Medicare and Medicaid utilization has contributed in no small measure to the increase in hospital costs we have witnessed in recent years. Thus, it would seem that the last thing we would want to do, if the idea is to keep hospital costs down, is to adopt a Kiddicaid program that will help drive them up. Similarly, there is a certain inconsistency in promoting a hospital cost containment program on one hand while insisting on an outreach program of early and periodic screening, diagnosis and treatment for children on the other. Certainly we want the best for the children of this nation, but just because a proposal is directed at children does not mean that it is any less susceptible to the problems of over-utilization and cost inflation that have plagued similar programs directed at different age groups.

Beyond the obvious financial difficulties, H.R. 4962 has some other basic weaknesses. Of these, two stand out: the increase in governmental, at the expense of parental, responsibility for children and the substitution of bureaucratic for physician decision-making in the area of patient treatment. Once it becomes an accepted fact of life that the government, rather than poor parents, should determine what kinds of medical testing and treatment their children should have, then it could later be argued that the government should have the right to put poor children in foster homes or government run youth camps supposedly for their physical or material benefit. And if it becomes accepted policy, as it is already becoming, for HEW to issue rules and regulations governing the types of screening and testing that should be done on children, and how it should be done, what does that do to the physician's exercise of judgment on what's best for his or her patient? If the family is to continue to be the basic organizational unit of society, then the heads of the family rather than some faceless bureaucrat must have ultimate responsibility and authority. And the physician, working with the heads of the family, must be able to rely on his judgment, as a professional, to assist in the fulfillment of that responsibility.

Two other points are deserving of mention. One involves the wisdom, or lack thereof, of including headstart agencies in the list of those who would be deemed qualified to be a health care provider. The other relates to H.R. 3434, the Social Service and Child Welfare Amendments of 1979, which the House of Representatives has already passed. That bill, would appear to provide Medicaid coverage, up to age 18, for children adopted under the aegis of AFDC program; H.R. 4962

has language in its giving the states the option to provide similar coverage. While state option is preferable to federal mandate in this, as well as other areas contemplated by this legislation, the overlap suggests even more strongly that much of what is contemplated could be accomplished under existing law.

The central problem with H.R. 4962 is not that it is benevolent; it is that the benevolence is misplaced. All consideration of the taxpayer aside, adding fuel to the fires of inflation by starting up what amounts to a Kiddicare program, is likely to put more children in the category of those needing assistance than it will provide care to those already in that category. It is a Catch 22 situation—by trying to throw money at a problem we only make it worse—and the only way to remedy it is to subordinate emotional considerations to good common sense by keeping the cycle from starting. That means rejecting H.R. 4962, not because anyone is against children, but because everyone should be opposed to fanning the fires of inflation and government overregulation—which threaten children, their parents, their grandparents trying to survive on fixed incomes and every other American with a stake in the future of this Nation.

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